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The Manitoba Flood as I Saw It

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FOR DAYS and weeks we had been reading and hearing about the plight of the people in southern Manitoba and while geographically they were close to Winnipeg the possibility of the flood reaching Winnipeg seemed somewhat remote. It was difficult to imagine that a great city like ours could be flooded. Everyone was fairly sure that any day the crest would be reached and the waters would begin to recede. But they did not recede! We were to see the amazing phenomenon of the Assiniboine River, which normally flows eastwards, eventually flowing westwards. At the junction of it and the mighty Red there was no room for the Assiniboine and it was forced back.

Gradually one heard of one's friends moving a few things out of basements "just in case." Others were looking for high rubber boots and pumps to clear seepage out of basements, while others were helping to fill sand-bags for dykes in outlying parts of the city. The daily papers and the radio were constantly informing us as to how many feet the river was "above datum"—an expression which Winnipeggers were to come to loathe. Daily the threat grew and daily more people were pumping basements. Large buildings in the downtown area were pumping volumes of water out of basements. The army was called to assist the weary civilians on dykes. Women with children were being advised to leave the city at once. Depots were being set up to collect sandwiches for dyke workers. Theatres, restaurants, and schools were closing. The Red Cross was deluged with calls asking for help and from people wanting to help. Everyone was being

HELEN L. WILSON

advised where to go for typhoid vaccine. Then the heavens literally opened, the "rains came," and the flood was on.

The flood for us at Deer Lodge (D.V.A.) Hospital began about midnight of May 5 when we had an emergency call from the municipal hospitals that a dyke had collapsed and the water was already in the King Edward, the King George, and the lovely new Princess Elizabeth hospitals. Staff was called and beds were quickly made up in an empty ward for 57 tuberculosis patients. The next day, Sunday, a service club came and assisted in moving out our Red Cross Arts and Crafts Department and in its place setting up beds for more tuberculosis patients. These two wards were to be filled and emptied several times in the next few weeks by patients from all over Winnipeg and St. Boniface who were collected here and moved on to hospitals and sanatoria out of Winnipeg. Their own medical and nursing staff came with them.

On Sunday, May 7, we received calls from the Children's Hospital and the Shriners' Hospital asking what facilities we might be able to provide should the worst come to the worst for them. The Red Cross was ready and willing to vacate their Lodge adjoining the hospital, if need be. On Monday, May 8, it became necessary. Service clubs and Deer Lodge staff helped clear the Lodge, set up and make beds for 53 patients from the Children's Hospital. One might associate considerable confusion and noise with such a move but this was not so. Within about three hours from the start of the move from the C.H. in the north end of the city to Deer Lodge on the extreme west, everything was quiet, the children were asleep, and the new Children's Hospital was functioning smoothly. The foyer was used for administration headquarters, one bathroom served as a service room, and the other larger one for medications, treatment trays, etc.; formulae and patients' meals were made in the kitchen. The reading room accommodated the patients on separate technique. The older patients were assigned to the large sitting-room while the tiny babes in respirators and incubators were by themselves on one side of the auditorium adjoining the sitting-room. Bedrooms upstairs normally occupied by relatives of seriously ill patients in Deer Lodge Hospital were used by staff nurses of the C.H. Student nurses were housed in a nearby school and classes were carried on as usual. Meals were prepared and served to the staff in the Legion Canteen. The smoothness with which this move was accomplished must be attributed to the administrators from the Children's Hospital who carefully looked over the space the day before and expertly and quickly fitted their whole hospital into it.

That night, May 8, an emergency meeting of medical and nursing agencies was held at the Red Cross Headquarters to discuss and implement a plan whereby medical and nursing care would be assured to the people of Winnipeg. As a result, a Medical-Nursing Division was set up at Flood Headquarters through which all doctors and nurses who could do so were registered for service and to which all requests for such help were to be directed. The work accomplished by this nursing committee, under the leadership of Miss Lillian Pettigrew, executive secretary of the Manitoba Association of Registered Nurses, is a story in itself, and one which I could not attempt to tell.

On Tuesday, May 9, amid snow and rain, the Shriners' Hospital with 20 wee ones was evacuated to the Red Cross Lodge. This building now accommodated two hospitals — the Children's and the Shriners'. A day or two later the Shriners' Hospital decided to run for higher ground and moved out by rail to the Regina General. Also, on May 9, Deer Lodge was asked to make room for patients who were to be evacuated from nursing homes. By discharging as many D.V.A. patients as safely possible and evacuating entire wards, approximately 92 beds were made available. These beds, like those

provided for the tuberculosis patients, were occupied and emptied many times over. Nursing service was provided by the City Health Department, Deer Lodge Hospital, the Children's Hospital, nurses from Miss Pettigrew's committee, and volunteers. A group of high school girls and women who lived in our vicinity were organized to come to Deer Lodge three times daily to help with the feeding of these elderly patients. Doctors on the Deer Lodge staff worked day and night, assessing, screening, and documenting the patients for evacuation. The dangerously ill were not moved on. All in all we admitted 410 civilian patients among whom were two patients in iron lungs who were brought out by the navy in a *Dukw* from the King George Hospital.

Gradually most of the hospitals in Winnipeg and St. Boniface were ceasing to function. It became evident that the Winnipeg General and Deer Lodge were going to be called upon to care for most of the sick. The new maternity pavilion at the General was quickly opened and the beds thus released in the main building enabled St. Boniface to evacuate the remainder of their patients. Students from St. Boniface went to the General and their classes and lectures were carried on there.

The Department of Veterans Affairs was directed to move as many of their patients as possible in order to assure the city of hospital beds. Our days became a series of large admissions of civilian patients and evacuations of D.V.A. and civilians. The nursing department of Deer Lodge was advised that a train with a certain number of coaches and carrying a specified number of stretcher and walking cases would be leaving Winnipeg at a given time. A nursing and orderly staff was chosen for each train. One D.V.A. doctor and sometimes two accompanied each train. At one time 25 D.V.A. nurses and about 30 orderlies were out on trains as our patients were moved to Regina, Saskatoon, and Calgary. The doctor was responsible for drawing from the dispensary all drugs he would require. The chief orderly's office was responsible for drawing from hospital stores bed-pans, urinals, toilet tissue, and one or two wash basins. For each train the Central Supply Room made up a standard carton of syringes, needles, intravenous sets and solutions, catheters, forceps, thermometers, dressings, sponges, alcohol, adhesive, kleenex, sputum boxes, paper bags for refuse, soap, and a few changes of pyjamas, towels, and face cloths. One senior nurse on the train was responsible for patients' documents. D.V.A. patients' documents went in one bundle. Civilian patients' documents were pinned on each of them in a large envelope clearly marked with the patient's name. Patients were moved out by army stretcher bearers in army ambulances to the trains.

During those hectic days our phones never ceased ringing. The switchboard operators became hoarse. Kind-hearted citizens wanted to come to the hospital to help—dozens came directly to the hospital. People in the vicinity of the hospital wanted to give shelter to our nurses who might be flooded out. Numbers of relatives came looking for patients who had been moved from nursing homes, often to find they had again been moved to points in Manitoba and Saskatchewan. Many of these good people, exhausted from working days and nights on dykes, on finding their relatives gone, gave vent to their emotions in anger, some in tears.

In the event of the collapse of the power station, which daily was a grave possibility, we were prepared to carry on. A large generator, one of several flown in from the United States, was on the hospital grounds to provide light and power for a section of the hospital. A site was decided upon and plans were ready to set up outdoor army style kitchens when and if power failed. We came within hours of resorting to these facilities.

About May 17 and 18 the river ceased rising and we received no further orders to evacuate patients. On May 19 I had an opportunity to

fly over the whole flooded area of Manitoba. It was an unbelievable sight!

On May 30, our first group of nurses and orderlies set out to bring home our patients and by June 2 all our patients were back. Not till September 29, almost five months later, did we say goodbye to the last of our evacuees when the two respirator patients were moved home to the King George Hospital.

This is not by any means the story of the flood—it is merely the highlights of "the flood as I saw it."

HELEN L. WILSON, R.R.C.
President
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Isolated Isolation Hospitals

MARY L. SHEPHERD

Average reading time — 9 min. 36 sec.

HOW LONG AGO it seems since that cold, wet early morning of May 6 when the flood waters of the Red River reached and inundated the grounds of the Winnipeg Municipal Hospitals as the river surged over great areas of Manitoba and, finally, Winnipeg.

Now, eight months later, we are still far from normal at the hospitals due to the fact that our basements, the main floor of the King George Hospital, the laundry, power house, and all other buildings stood for weeks in the filthy silt-filled river water.

We have had every available means of cleaning up these buildings, rebuilding damaged areas, relaying of floors, and every type of repair and reconstruction work, yet we still have no basements ready for use. Several wards are still filled to capacity with furnishings and stores from the basements and main floors of all our buildings and so cannot yet be made ready for occupancy. Our x-ray department is still not in operation. The new Princess Elizabeth Hospital for the chronically ill (with every unit ready last May) has still never been opened, though reconstruction work has been carried on throughout this time. The laboratory is yet to be completed. Our classroom cannot yet be used. One elevator is still out of order and the floor of the reception room in the nurses' residence is bulging in many places from flood waters which were so long beneath it.

Some rather interesting facts may help to give you an insight into how slowly rehabilitation takes place.

On May 6 we evacuated all of our tuberculosis patients to Deer Lodge Hospital and from there to the Saskatoon and Fort Qu'Appelle sanatoriums. Our own staff nurses were sent wherever the patients went.

Some of us remained at the King George Hospital with our Eskimo patients, two patients in respirators, and three small babies with communicable diseases.

Then came a call for space for more communicable diseases. They could not easily be brought in by boat so we finally set up a second isolation unit in the already-evacuated Children's Hospital. Again we divided our staff—some to still remain with our few patients in the midst of the "lake."

On May 13 the army decided to evacuate the few of us who remained —one patient went to the Winnipeg General Hospital, two others to Deer

Miss Shepherd is superintendent of nurses at the Winnipeg Municipal Hospitals, Man.

Lodge Hospital. Our Eskimo patients were sent to Sioux Lookout while the tuberculosis patients from a second Winnipeg sanatorium, who were being cared for with ours, were sent to Fort William, Ont.

What a task it was to keep a complete record of where all these patients were, how many staff were with each group, notifying the postal authorities of each move, and keeping a record of the hours of nurses now scattered in three provinces!

We no sooner got ourselves orientated when we again had to move to allow the Children's Hospital patients to return. So back we went to the only place available—the King George Hospital—by boat, on June 2.

Our nurses' residence was not occupied until July 6. We did not get our Eskimo patients and Deer Lodge patients back until July 10. The patients at Saskatoon and Fort Qu'Appelle returned July 12. The elevator in the King George Hospital was not operating until August 2. Our lights came on again August 10. The ground lights and switchboard were again in operation and the last two patients returned September 29. Our operating room was finally used again five months after the flood—on October 18.

To return to the days of the flood, we were truly "isolated" for we still operated the King George Hospital in the midst of a lake of water up to ten feet in depth in the hospital grounds, and with water everywhere as far as we could see in any direction. No one occupied any of the homes in the surrounding districts for some were half under water. Smaller homes were in water to the eaves.

We will always remember hearing the news of the towns and farms in southern Manitoba being under water; of hundreds of people homeless and arriving in Winnipeg to seek shelter; of hearing that the river was rising hourly 25 feet, 26 feet, 27 feet—and finally over 30 feet above normal safety level; of its steady approach to Winnipeg during those cold, dark, wet days of apprehension. Thousands of men, women, and children were helping to build dikes or serving food to dike workers.

Looking across the grounds at a corner of King George Hospital (l.), nurses' residence (c.), Princess Elizabeth Hospital (r.).

We, of the nursing staff, took no chances on whether the water would come or not. We moved all of our equipment and supplies to one of the top floors three weeks before the flood came, then assisted the more optimistic departments when they had to move in rather a hurried manner. The night before the flood struck we worked right through, moving the remaining supplies from the already-flooding basements. At 4:00 a.m. we were called to assist in the evacuation of the patients during which time a flash flood filled the basements, hurling sand-bag embankments as though they were feathers.

I shall never forget the quiet calm of every patient and every member of our hospital personnel as ambulance after ambulance took the 160 tuberculosis patients to safety. By 7:00

Hospital personnel en route to Princess Elizabeth Hospital to help carry supplies from the first floor as basements were filled to the ceiling with water.

Boat arriving at King George Hospital while three student nurses stand on top step of front entrance. This was the only day we were able to get out in the sunshine on front steps as they "went under" the water the following day. King Edward Hospital can be seen across grounds.

a.m. the last ambulance was about to go when I managed to send our two smallest Eskimo children over for my parents to care for until after the emergency. Again they went quietly, never doubting that we would see that they were safe. In fact, the ambulance drive delighted them.

The hospital grounds were quickly inundated. Nearby cars and a tow-truck were completely submerged in a very brief time. These cars and our ambulances remained for weeks under water.

We were now completely isolated for we had no boats and our switchboard had ceased to function. All of our electricity was suddenly cut off. We had no radio and no telephone. There we were with 17 patients to care for. How to begin, we wondered, and how could we keep them warm with no heat or hot water! For only a moment we were bewildered—perhaps from loss of sleep, for no one could get in to relieve us—but we very soon became adept at improvising.

Our nursing care was very limited for it was much too cold to even strip a patient's bed. We concentrated on keeping them warm with blankets under and over them and suits of underwear and sweaters. We saw that they had good hot meals and kept them comfortable. They knew that we would not leave them. When the emergency electricity was installed on that one floor only (and in the main kitchen) we placed all of our heat lamps near the patients' beds, particularly where the three babies were.

We very soon had to wear more than our white uniforms. By the end of the first day we were only too glad to don hospital underwear, slacks, sweaters, and warm dressing gowns! Even then we were never warm.

Out technique had to be improvised, too. Scrubbing our cold hands under cold water was almost our greatest problem.

We no longer had steam for boiling dishes, trays, basins, etc., so had to soak them in solution, after which they were carefully washed in soap and water (the latter obtained from fourth floor!). Our laundry had to be taken by boat to downtown laundry establishments.

Garbage disposal was also a problem. The cans were placed in a special boat which was tied to a tree in the middle of the grounds until army

trucks could meet the boat and take the garbage to the incinerators.

I wonder how many hundreds of times we climbed those stairways? Our telephone was on one floor, our improvised offices on another, the kitchen and dining-rooms on the top floor.

However, life in this rather damp, isolated area was far from being unhappy. The nurses and other personnel showed a greater loyalty and interest than could possibly be found at any other time. This loyalty was deeply appreciated. We could hardly get them away for their days off—they were afraid they might not get back! A few, who did not live in residence, came to work daily by boat.

In the evenings we had many very happy times with much laughter in the one "community" room which housed the telephone and a newly acquired stove (which proved to be rather temperamental at times!). Here we rested and talked and played card games in the evenings, then enjoyed hot coffee and lunch.

We will never forget the sight of the first boat coming along Morley Ave.—nor the beautiful sunset across the waters and a canoe silently gliding through it between the hospitals—nor the kindness of one of our aldermen, a member of our Hospital Board, who manned his motor boat up and down Morley Ave., day after day, in the rain and cold—nor the rounds made by the Fire Department and police to see that "all was well"—nor the night the members of the Fire Department got a hurried call, rushed into their boat, turned it quickly around—and crashed into the nearest tree!

The ground lights were submerged, with only the globes above water. Our only entrance to the King Edward Hospital was by way of the fire-escape and through the second-floor windows.

I finally contacted all members of our staff, sent some to be with our patients and had the others "stand by" the first day after the flood struck us. What a wonderful feeling it was to know that they were ready to go wherever needed and to undertake whatever duty was asked of them!

Two respirators being removed from King George Hospital by the Navy.

That very night at 3:00 a.m. we chanced to hear an urgent call for help from the Winnipeg General Hospital which was at the time taking in the St. Boniface Hospital patients. Thanks to our staff I was able to telephone at once and give 17 names and 'phone numbers of nurses ready and waiting to help.

Making rounds was done by boat and "ambulance" (improvised from a truck). It took four hours for we had to travel around so many flooded subways and streets to get to the Children's Hospital and Deer Lodge and return to the King George Hospital.

The rehabilitation program was to be a very slow one and, at first, seemed a gigantic task. The floors, walls, ceilings, lights, and cupboards were covered with thick, slimy silt. Cupboards crumbled when moved, after many weeks under water. Clearing the silt and dirt was one of the biggest tasks, then followed weeks and months of reconstruction work.

Our classroom was completely demolished and with it went the wonderful colored pictures of various communicable diseases which we had spent years in collecting and which had been invaluable in our teaching program.

After the floors had all been relaid, walls plastered and painted,

Ambulance marooned beside front entrance. Medical superintendent's home in background of picture.

we finally were able to open one more floor though the others remain clogged with equipment until the basements are completed.

Our affiliation program had to be completely re-organized but this was easily done, thanks to the very splendid cooperation of our affiliating schools.

Another gigantic task was that of identifying the belongings of all our tuberculosis patients, after employees and volunteer workers had rushed all furniture, patients' clothing, and personal belongings from one floor to the next. No one will ever know the weeks that were spent sorting out everything, identifying clothing by laundry numbers, envelopes with names on or by any means possible, then wrapping them and tagging them until the patients returned. It had not dawned on those carrying the dressers, tables, clothes lockers, etc., upstairs that such confusion could occur. Thanks to the staff who undertook this work, all belongings were safely returned to all patients.

And so we have learned to adjust quickly to an emergency; how to improvise; and, most of all, we have learned and experienced wonderful cooperation and loyalty in sharing all of these experiences.

How appropriate was the slogan of Manitoba during the 1950 flood—"We're weary and wet—but we'll win."

Winter Driving Hazards

Winter inevitably brings added risks for those who travel streets and highways. The importance of weather conditions in the traffic accident picture cannot be minimized. These unfavorable conditions are not so much a *cause* of traffic accidents as they are factors influencing the frequency and severity of accidents. It has been estimated that in one out of every five traffic accidents, visibility was sharply diminished by rain, snow, sleet, or fog. These conditions are still further troublesome in the way they alter the surface of an otherwise safe highway. After weeks of icy road conditions, a driver may relax when one or two days of warm weather come along. Alternate patches of slick and clear road surfaces tend to lull the usually cautious driver into a false sense of security. Remember, you can't stop on an icy dime!

Ontario

The following are staff changes in the Ontario Public Health Nursing Service:

Appointments: With the annexation of the Township of East Whitby to the city of Oshawa, *Mary Murdoch* (Gen. Hosp., Saint John, N.B., and University of Toronto general course), formerly public health nurse in the Township, will join the Oshawa board of health; *Lyla Groat* (Toronto Gen. Hosp. and U. of T. gen. course) to Owen Sound board of health; *Eva Rieder* (Massachusetts Gen. Hosp. and U. of T. gen. course) to Kitchener board of health.

Resignations: *Agnes (Bray) Beaumont* from Forest Hill Village board of health; *Mrs. Betty Brown* from Owen Sound board of health; *Jean Macfie* from Peel County health unit; *Jessie Smith* from Kirkland-Larder Lake health unit.

Possible causes of the brittleness of fingernails, that induces frequent jagged breaks, have been found to include the use of nail lacquers and their removal by oil solvents, unbalanced metabolism due to vitamin deficiency or hormone imbalance, skin diseases, and neurotic habits such as nail-biting.

Public Health and Medical Aspects of an Aging Population

A. H. Sellers, M.D., D.P.H.

In opening this symposium my chief function is to present some statistical highlights on the problems created by the lengthening life span—to note the essential changes in mortality, the profound changes in our population structure, the greater need for medical, hospital, and nursing care at older ages; and, by implication at least, the impact of these facts on the health and medical problems which we must plan to meet.

Mortality Changes

During the past 50 years, outstanding reductions in mortality have been made in Ontario. These reductions have been largely in the mortality from a comparatively few causes—spearheaded by the reductions in maternal mortality, infant mortality, and deaths from diphtheria, tuberculosis, typhoid fever, respiratory diseases, rheumatic heart disease, and appendicitis. [1, 2, 3]

Deaths from the communicable diseases have been reduced by 90 per cent during the past 50 years. Deaths from diphtheria declined from 772 in 1901 to 10 in 1948; deaths from typhoid fever fell from 500 in 1901 to 4 in 1948; deaths from tuberculosis dropped from 3,243 to 825. This has been achieved by the collective effect of a number of causes: improvements in water supplies and sanitation; decline in virulence or increase in natural immunity; protection of the community by immunization procedures; improvements in medical care, personal hygiene, education, and housing; new discoveries in chemotherapy.[4]

The mortality changes have been characterized by a marked decline in the mortality rate in all age groups under 50 years. In the 40-49 group there were only two-fifths as many deaths as in 1900; in the 30-39 age group the rate was reduced by almost two-thirds; and in all age groups under 30 by fully three-quarters of the rate in 1900-02.

In spite of the great declines in mortality which have been recorded, the total death rates in the age groups 50-59 and 60-69 years have, until

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TABLE I

Mean Death Rates by Age-Group
Ontario—Selected Periods

Age	*1900-02*	*1901-05*	*1940-42*	*1944-48*
1-4	10.78	11.00	2.48	1.59
5-9	3.52	3.28	1.04	0.94
10-14	2.46	2.52	0.90	0.71
15-19	3.81	3.72	1.42	1.12
20-29	5.61	5.51	1.85	1.42
30-39	6.50	6.28	2.68	2.25
40-49	8.14	7.98	5.14	4.86
50-59	12.69	12.84	12.10	11.00
60-69	27.62	27.22	27.40	26.10
70+	95.83	99.80	92.03	85.92

TABLE II

EXPECTATION OF LIFE—VARIOUS PERIODS

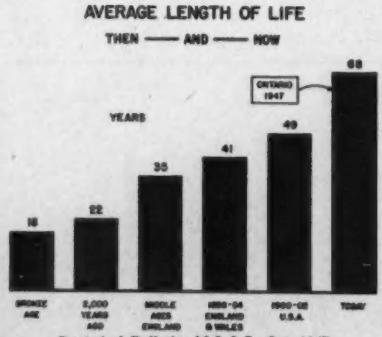
Age	Males					Females				
	1901	1931	1941	1941	1947	1901	1931	1941	1941	1947
	U.S.A.	Can.	Can.	Ont.	Can.	U.S.A.	Can.	Can.	Ont.	Can.
0	48.2	60.0	63.0	64.6	65.2	51.1	62.1	66.3	68.4	69.0
20	42.2	49.0	49.6	49.6	50.5	43.8	49.8	51.8	52.4	53.3
40	27.7	32.0	31.9	31.5	32.4	29.2	33.0	34.0	34.1	35.0
50	20.8	23.7	23.5	23.1	23.9	21.9	24.8	25.5	25.4	26.3
65	11.5	13.0	12.8	12.6	13.2	12.2	13.7	14.1	14.0	14.6

quite recently, shown very little change. This may be due in part to bringing into these age groups substandard people saved from earlier death by the many factors which have combined to reduce mortality in the age groups under 50.

There is no justification, however, for the cynical notion that the causes of death after age 65 are not of great importance. In due time the "preservation of life at 70 will take its rightful place as no less important than was the saving of a life at 50 half a century ago."[4]

EXPECTATION OF LIFE

The expectation or average length of life is a good measure of the extent to which man has succeeded in gaining control over his environment. This figure expresses the mean duration of life to be expected by newborn infants or by people who attain a given age, *or* the average number of years that a person of a given age will probably survive—on the assumption that the death rates will not change.



Statistical Bulletin, M.L.I.C., Oct. 1947.

Fig. I

The average duration of life has progressively increased from ancient times but it has undoubtedly increased more in the past century than in all prior centuries since the dawn of civilization (*Figure I*).

The average length of life of prehistoric man was perhaps 18 years.[5] Longevity in Roman Egypt about 2,000 years ago has been estimated by Karl Pearson to have been about 22 years. Figures for the Middle Ages suggest an expectation of life at birth of possibly 35 years. According to life tables constructed by the eminent statistician, William Farr, for England and Wales covering the period 1838-54, the average length of life had then increased to 40.9 years —a gain of a little more than five years over the figures for the Middle Ages. In the United States, the average length of life rose to 49.2 years in the period 1900-02.

Spectacular gains have been achieved since the opening of the present century and, in 1947, the expectation of life at birth stood at 68 years in Ontario. From an expectation of 51.2 years for a female newborn baby in 1901, today the expectation in Ontario is 70 years[6] (*Table II*).

To express this fact in a different way, under the mortality conditions which prevailed in 1900, a group of 100,000 male babies born in 1900 would be reduced to 39,245 by the time they reached their 65th year, while with the death rates of 1947 the number of survivors at age 65 in Canada would be 64,604. In other words, the chances of a boy born in 1900 celebrating his 65th birthday were less than 40 in 100. In 1947 the chances were 65 in 100.[7] For females the chances are 72 in 100.[8] Under prevailing mortality rates, half the girls now being born will live to age 75 and half the boys to age 72.[6, 8]

During the last 50 years the expectation of life at birth has improved by 17½ years for boys and by 19 years for girls. In 1900, a young man of 18 in Canada had 51 chances in 100 of surviving to 65; in 1948 this figure was 70 in 100. Medical and public health leaders could hardly have expected such gains within two generations. Even in the last 15 years the average length of life has increased by 5 years for males and by 7 years for females.

TABLE III

EXPECTATION OF LIFE—SELECTED AGES—FEMALES
1900—1931—1947

Age	*U.S.A. 1900-02*	*Canada 1931*	*Canada 1947*
0	51.1	62.1	69.1
1	56.4	65.7	70.9
5	56.0	63.2	67.5
10	52.2	58.7	62.8
15	47.8	54.2	58.0
20	43.8	49.8	53.3
25	40.0	45.5	48.7
30	36.4	41.4	44.1
35	32.8	37.2	39.5
40	29.2	33.0	35.0
45	25.5	28.9	30.6
50	21.9	24.8	26.3
55	18.4	20.8	22.2
60	15.2	17.2	18.2
65	12.2	13.7	14.6
70	9.6	10.6	11.4
75	7.3	8.0	8.6

EXPECTATION OF LIFE AT VARIOUS AGES

Most of the gain in expectation of life has been made at ages under 50. There has been comparatively little gain in the age groups of 50 and over (*Table III*).

The mean duration of life to be expected among baby girls born in Canada in 1947 was 69.0 years; at age 50 the expectation was 26.3 years. The average length of life remaining to Canadian males at age 65 is 13¼ years; for females—14⅔ years. The more vigorous will, of course, live much longer than the average.

The expectation of life at age 65 is now greater in males by only 1 year over what it was in 1900; in females it is greater by only 2 years.

In countries in which the health standards are high, the expectation of life at birth is not far from the biblical threescore years and ten.[10] The best records are found in New Zealand, England and Wales, Australia, Denmark, Sweden, and the United States. India in 1931 had an expectation of life at birth of slightly less than 27 years, not much higher than that estimated for Rome 2,000 years ago.

THE FUTURE OUTLOOK FOR LONGEVITY

The outlook for further gains in the expectation of life in the future would seem to be favorable. We still have a higher infant mortality rate than in England and Wales, United States, Sweden, Holland, New Zealand, and Australia. Wider application will be made of existing knowledge in medical and sanitary science.[11] Further advances will be made, too, in our standard of living, nutrition, housing conditions, protection against occupational hazards, and accidents. All these forces can effect further reductions in mortality and thus improve longevity.[12] Discoveries in the fields of cancer and the degenerative diseases would add significantly to the present average length of life.[13]

CHANGES IN POPULATION STRUCTURE

Control of diphtheria, typhoid, smallpox, tuberculosis, and other communicable diseases; better medical care; better education; better working conditions; better nutrition, hygiene, and sanitation have all been responsible for a lowered mortality, a greatly increased life expectancy, and for a profound modification of our population structure which influences the whole picture of health and disease and which will affect the whole structure of our society.

Until fairly recent decades our population was characterized by its youthfulness. Heavy immigration of young men and women and high birth-rates swelled the proportion of people in the younger age groups and diminished the relative importance of those in the age group 65 years and over. Subsequently immigration was reduced, our birth-rates declined, and life conservation at the earlier ages brought more and more of the population into the older age brackets[14] (*Figure II*).

There is no arbitrary boundary between senility and old age. Many people at 65 are still vigorous and gainfully employed, while others are showing signs of aging. For convenience, I shall associate the term "aged" with those who have attained their 65th birthday. This is an arbitrary but convenient definition and no connotation of physical infirmity or economic dependency is necessarily associated with it.

Our old people are increasing at a substantial rate. In 1901 there were 120,000 persons aged 65 and over in Ontario; in 1921 this had jumped to 172,000 and by 1941 to 301,000. It is estimated that in 1951 the numbers will increase to 400,000 and by 1961 to 500,000.[15] The number of people in the age group 65 and over has doubled in the last 25 years (*Figure III*). Expressed in another way, in 1901 only 55 persons in every 1,000 were 65 years of age or over. In 1931,

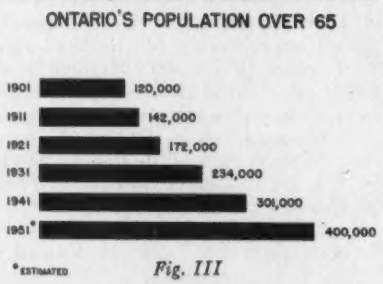
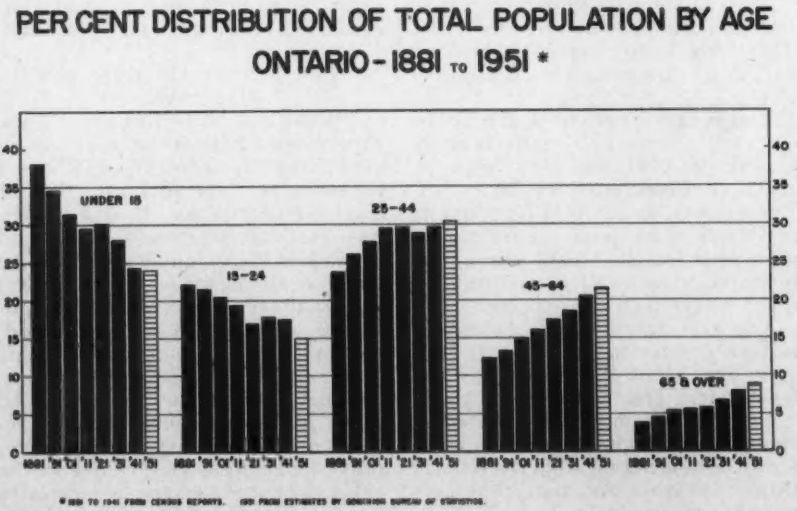


Fig. III



Medical Statistics Branch, Ont. Dept. of Health

Fig. II

the figure was 68 and now it is something over 90. By 1971, it is estimated that 12.6 per cent of our population, or one in 8, will be 65 years of age or over. This will be a 50 per cent increase in 25 years (*Figure IV*).

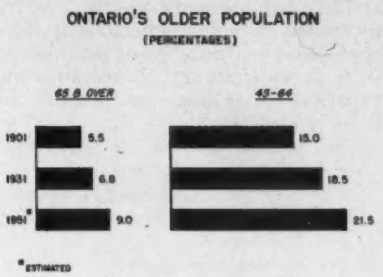


Fig. IV

Ages 45-64 Years

Another important effect of the reduction in our mortality rates is the greatly increased number and proportion of the population who survive to begin and to complete the working years of life. This tremendously important point is often obscured by the emphasis placed upon the problems of "old age." The improved mortality rates at all ages under 50 years ensured us a greatly increased number of years of productive work. The greatest proportionate increase in our population is in the age group 45-64 years. In 1901, 326,000 persons or 15 per cent of our population were in the age group 45-64 years. When the 1951 census is taken we may expect to find 900,000 persons, or 21 per cent of our population, in the age group 45-64 years and 400,000, or one in every 11 persons, 65 years of age or over. By 1961 we will have something over 1,200,000 persons in the age group 45-64 years and possibly half a million at 65 years of age and over (*Figure V*).

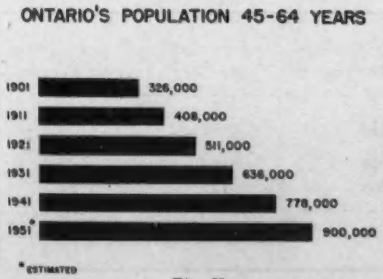


Fig. V

Mortality Changes

At the beginning of the century, the first and second ranks among our causes of death were held by tuberculosis and pneumonia. These two diseases accounted for over one-fifth of the total mortality. Since that time, they have fallen to sixth and seventh place and now contribute barely one-fourteenth of all deaths. Today, cardiovascular-renal disease and cancer account for two-thirds of all deaths.

The age picture of mortality has also greatly changed. In 1900-02, only 43.2 per cent of all deaths were at ages 50 and over—today over 75 per cent fall into these age groups (*Figure VI*).

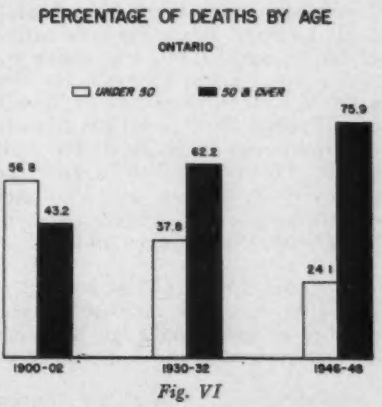


Fig. VI

The Health of Old People

In 1944-48 diseases of the cardiovascular-renal system (62.7 per cent), cancer (14.7 per cent), accidents (4.2 per cent), diabetes, pneumonia, and tuberculosis caused 90 per cent of the deaths of persons at 60 years of age and over. Two-fifths of all deaths were attributed to diseases of the heart and coronary arteries (*Figure VII*).

The diseases which account for the majority of deaths in the older age groups are chronic or degenerative rather than acute or infectious. Their incidence is long-term and relatively

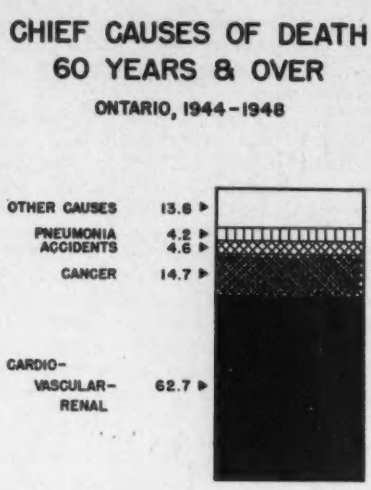


Fig. VII

unvarying. Concerted efforts to reduce them have been started only fairly recently. While the expectation of life at age 50, 60, and above remains approximately the same now as 20 or even 50 years ago, the health of old people as a group has already improved and it is inevitable that in the future we shall reduce the causes of invalidism at older ages even simply as an indirect effect of accomplishments at ages under 65.

The Medical Issues

The tremendous increase in the number of individuals age 65 years and over stresses the importance of being prepared to meet the medical, nursing, and related needs which such changes in population structure are bringing. The seriousness of the medical and nursing issues involved in our "lengthening life span" are emphasized not only by the greatly increasing numbers of persons at older ages but by a number of established facts in sickness and hospitalization experience.[16] These are worthy of brief reference:

(a) *Incidence of illness:* The incidence curve of illness is similar to that for mortality. The incidence of illness changes little from 10-44 years but rises steeply after age 60.

(b) *Prevalence of disabling sickness:* The percentage of persons disabled by sickness or injury at ages 45-54 is twice and at ages 55-64 years is three times what it is at ages 15-44 years. About one person in 8 over 65 years of age suffers from some form of disability. Illnesses causing disability for a week or more involve 28 per cent of older people each year (*Table IV*).

(c) *Disability rates:* The duration of disability or length of stay in hospital both increase threefold at the older ages. The number of days of disabling sickness per person at all ages is 9.8 days. At ages 65 and over it is almost 33 days.[17]

(d) *Chronic disease:* There is a steep rise in the prevalence of chronic disease with age. At ages 70 and over the figure is 5-6 times what it is at younger ages (*Table V*).

(e) *Invalidism:* The number of invalids in the population (persons permanently

TABLE IV

Frequency, Prevalence, and Severity of Illness
U.S.A. National Health Survey*

Age Group	*% Disabled on Day of Survey*	*Disabling Illnesses per 1,000 Persons*	*Days Lost per Case*	*Days Lost per Person*
Under 15	4.2	232	26	6.0
15-24	2.5			
25-64	4.4	144	63	9.1
60 and over	12.1	265	123	32.6
All Ages	4.5	172	57	9.8

*National Health Survey, 1935-6.

TABLE V

CHRONIC DISEASE AND DISABILITY*
Rates per 1,000 Population at Age

Age	*Chronic Disease*	*Invalids*†
Under 5	34	1.6
5-14	68	3.1
15-24	83	4.6
25-34	159	5.7
35-44	221	10.8
45-54	274	16.2
55-64	344	28.5
65-74	466	55.0
75-84	522	76.1
85 & over	557	101.0
All Ages	177	11.7

*National Health Survey, 1936.
†Disabled for the year.

disabled by chronic disease) varies sharply with age also. In the population as a whole the rate is 11 per 1,000. At ages 65-74, the figure is 55.0 and at 75-84 it is 76.1. Probably 70 per cent of our invalids are at ages 50 or over (*Table V*).

(f) *Medical consultations:* The average individual consults his physician 300 times in his lifetime—5 times per year at all ages for each sex. At ages 65 and over the consultation rate is twice what it is at ages 15-44 years.[4]

(g) *Hospital utilization:* There is a substantial increase in the average length of stay per case with increasing age from 50 on.[18] For every day of hospital care required per 1,000 population at ages under 65 years two days are required at ages 65 and over.

The steep increase with age in medical calls, disabling illness, chronic disease, invalidism, and hospital bed requirements clearly indicates that, since the medical and nursing problems of older ages are now relatively much more important, the medical, nursing, and hospital demands to be met in the future will be—to say the least—sizable! Every practising physician and nurse, every hospital superintendent, and every superintendent of nurses has felt the impact of the changes in age structure of the population in recent years. The weight of this impact is going to increase by 25 per cent in the next ten years! The pattern of disease incidence and mortality has shifted to feature the conditions of the older ages and those of a more chronic character. The Metropolitan Life Insurance nursing experience of 1925 showed that 50 per cent of the cases were nursed for acute medical conditions and only about 5 per cent for chronic diseases.[19] In 1945, on the other hand, the two figures were 14 and 28 per cent respectively—a complete reversal of emphasis.

While there are more cases of cancer, heart disease, etc., in the population today, however, a person age 65 today is no more likely to develop heart disease, hypertension, arthritis, diabetes, or cancer than he was 30 or even 50 years ago. The situation is simply that the person is more likely—if he develops the disease—to survive to the age of 65.

HOSPITALIZATION

Trends in hospitalization have been steadily upward over the years. Approximately one-third of the case load involves persons 60 years of age and over among whom cancer, diabetes, peripheral vascular disease, cerebral vascular accident, fractures of the hip or femur, prostatism, and senility predominate.[20]

The facilities for caring for illnesses in the home have a decided influence on the request for hospital admission. Congestion in urban areas with multiple families in one dwelling often makes it extremely difficult to care for even the most minor illnesses. Such difficulties are accentuated by the lack of available help within the home[20].

MENTAL HOSPITALS

The vast problem of mental disease is perhaps the most serious in the entire health field. In Ontario the number of patients in mental hospitals increased from 10,488 in 1931 to 16,459 in 1948—a ratio of 383 per 100,000 population.

The admission rates for mental disease are low at ages under 15 years and change very little from age 20 to

65; in the age groups beyond 65 years the rate is twice what it is in the younger age groups or at middle life.

Although only 9 per cent of our population is 65 years of age and over, 18 per cent of all our mental hospital beds are occupied by persons at these ages; an additional 37 per cent are in the age group 45-64 years. Of all first admissions, 23 per cent are 65 years of age and over and, of these, 80 per cent are patients with senile psychoses or psychotics with cerebral arteriosclerosis. There are many more of these patients not in hospitals but for whom some additional provision is required.

Nursing Personnel Requirements

Perhaps the most important single limiting factor today in relation to the care of the aged is the shortage of nursing staff. The potential source of nurses is the female population 17-20 years of age. The numbers of young women in this age group have been decreasing, in absolute numbers, since the late thirties and will not begin to turn upward until 1955 nor get above the present level until 1958. The ratio of females 17-20 years to total population has declined steadily from 1939 and this proportion will probably not regain its pre-war level until 1963-65. These facts pinpoint the nurse-power problem today.

Securing Facilities

It is our pressing medical and nursing problem to provide adequate hospital, medical, and nursing care for the large and increasing numbers of aged sick and persons suffering from disabling chronic conditions. Although chronic diseases find the majority of their victims at older ages, the term "chronic sick" includes all age groups—the infants and children with congenital heart disease, rheumatic heart disease, orthopedic conditions; adults with tuberculosis, progressive nervous diseases; older men and women with arthritis, cancer, arteriosclerotic and cerebral vascular changes, and senile conditions of all types.

It has been said that the aged, chronic sick have been inadequately cared for in the past and often receive scant attention.[21] Certainly our few hospitals for chronic diseases are filled to overflowing and many patients in need of institutional care must wait until beds are available. In addition, there is a pressing necessity for a larger number of beds for the care of aged invalids and semi-invalids.

Classification of the Aged Chronic Sick

The whole question of the management and care of the chronically ill, the aged sick, and the well old people is under review in many quarters. The Nuffield Trust Report on "Old People,"[22] the British Medical Association statement regarding the care and treatment of the elderly and infirm,[23] and the Report of the New York State Joint Legislative Committee on the Problems of the Aging,[24] among others, have emphasized certain specific points:

(a) The need for specific provision of hospital beds for those who may be classified as actively chronically ill—requiring active medical care. This might be effected by separate hospitals or by units in general hospitals (geriatric units).

(b) The need for specific facilities for the care of the senile and aged who require some nursing care and supervision.

(c) The need for adequate accommodation for well old people without homes or support (residential homes, homes for the aged, and the like).

(d) The need for the integration of homes for the chronic sick with a general hospital to ensure adequate follow-up.

(e) The need for the development of departments of geriatrics in the larger hospital centres where every modern facility of diagnosis and treatment can be provided for both in- and out-patients.

It is generally agreed that, wherever possible, the elderly and chronic sick should be retained in or returned to their own homes, provided there is sufficient help for their comfort and welfare and the home conditions are suitable. Many elderly and chronic sick will have to remain in a hospital or a home and such cases must be carefully classified so that they may

be best diagnosed, treated, and finally housed. It is considered that investigation should be undertaken, diagnosis made, and treatment undertaken in specially equipped geriatric units of a general hospital.

Geriatric Departments

Geriatrics is the science and art of medical service to the aging and the aged. It is concerned with the prevention of chronic disease and degenerative ailments and with the extension of vigor among the aging. It is argued that the provision of geriatric units in general hospitals, with all modern facilities and staff for investigation, diagnosis, and treatment, would raise the standard of work done, shorten the time of stay in hospital, and avoid the unnecessary blocking of beds by patients who could be treated sufficiently if they returned to their own homes or entered a residence. [21, 26]

Cosin has said that "improved care of the aged sick depends upon the organization of a geriatric department in the hospital system" and "a change in attitude toward these patients from that of resignation to the inevitability of endless months in bed, to active investigation, ensuring that each patient has the optimum chance of enjoying even limited activity and independence." [25]

Geriatric Rehabilitation

The object of geriatric rehabilitation is to restore the maximum degree of personal independence by remedial exercises. This calls for treatment by a team, including medical and nursing staff, physiotherapists, occupational therapists, medico-social workers. Mental stimulation, exercise, and physical aid all play a vital part. Rehabilitation is necessary if a large proportion of the older individuals are to find their added years both productive and enjoyable and at the same time not throw a burden on the younger and middle-age groups. Recreation and participation are important aids in decreasing hospitalization and the need for medical and nursing care.

Medical Education

The general feeling among medical educators is that integration of teaching in the various departments—medicine, surgery, psychiatry, etc.—will bring about a more thorough understanding of the medical problems of aging than any attempts to teach geriatrics as a separate subdivision of medical teaching. There seems to be much, however, to recommend geriatrics as a specialty. This branch of medicine is an important subject for the teaching of medical students and should form a specific part of their curriculum.

Medical Research

Greater emphasis on research into the diseases which accompany advancing age and into the process of aging (gerontology) must be encouraged and undertaken. This includes the fields of biology, physiology, psychology, and sociology. Fruitful research on the problems of old age, chronic illness, and premature aging will not only render old age more efficient and comfortable but will decrease the future tax burden for care of the chronically ill by reducing the number requiring care and decreasing the time that care is required.

Discussion

Since the elderly suffer twice as much from sickness as those of working ages, more and more of the work of the general practitioner and the nurse will be concerned with the care and treatment of the old people. Likewise in the hospital sphere, there will be a great and increasing demand for facilities for the care of the aged and the chronic sick. There are three medical and nursing aspects of importance:

(a) The training of the general practitioners and nurses upon whose care in the home a great part of the problem must continue to rest.

(b) The procurement of adequate hospital beds of proper type and the proper integration of these beds into a coordinated service. With the great pressure on hospital beds for acute cases, fewer are available for the elderly or

chronic patient, many of whom remain at home or in stagnant rest homes with inadequate facilities and inadequate nursing care.

(c) Discharging patients from hospital.

Until sufficient geriatric units are established, it is probably best for the aged and chronic sick to pass through the wards of a general hospital for investigation and assessment. Every attempt must be made to prevent such cases from becoming stagnant and blocking beds which should serve acute illness.

Cosin has said: "Get them up, keep them interested, and send them out is the attitude which is essential to prevent blockage of beds. If adequate accommodation were available for those who were ambulant, silting up of hospital wards might never occur. If there were adequate out-patient clinics, many admissions could be prevented. If there were plenty of trained personnel available, thousands of bedridden patients could be made active and self-supporting within a year or two."[27] Howell has said: "We must shift the focus of attack to the home, the out-patient clinic, and the hostel. To wait until the patient has been admitted to hospital, too often means that the time for treatment has passed and gone."[23]

General Comments

1. Our major health problem today is the diseases and conditions which attack our middle-aged and our elderly people. The awakened public interest in the problems of aging and old age is a manifestation of the public consciousness of the need!

2. The Ontario Health Survey Committee is engaged in a comprehensive review of the health problems of Ontario. This committee will undoubtedly put before the government some specific proposals for planned action in the field of chronic disease and aging.

3. Physiological age is not synonymous with chronological age. A man's usefulness does not necessarily begin to diminish at age 45, nor terminate at age 65. Recognition of this fact is of great significance not only to the employers but to the medical and nursing professions and to all community health and social workers.

4. The medical and the public health aspects of the problems of an aging population cannot be more than sketched here. There is a problem now; the problem is a growing one; it calls for planned action and conscious interest by medical and public health authorities. A study of these problems by a competent authority would be in order.

5. The changes which have taken place in the demographic picture require suitable adjustments in the public health and medical care programs. More and more activities must be concentrated on the diseases and conditions which affect the older age groups. Medical science and public health administration must adapt their services and facilities to meet the health needs of the middle-aged and older people.

6. It is imperative that we give due consideration to all practical measures which can be applied to the maintenance of the health of the aging and to the postponement of the day when they will require a great deal of assistance and eventually full bed-care. Where there has been deterioration in health or sickness or injury, the problem becomes one of rehabilitation.

7. The future calls for:

(a) A drive on those diseases which are specifically associated with older age.

(b) Increasing emphasis in medical research on the degenerative diseases and the problems of old age.

(c) Provision of much needed hospital, home, and rehabilitation facilities for the chronic sick and aged.

(d) Attempts to meet the demands for more medical and nursing care which are inescapable.

The objective of the combined efforts of all those concerned with the health and welfare of our people must be, to quote Dr. L. Z. Cosin, medical superintendent of the Orsett Lodge Hospital, Essex, Eng., to "seek to add not years to life but life to years," so that it will not again be possible for an elderly patient to say, "You don't

really live longer—it only seems longer."

* * *

Appendix A

Homes for the Aged Act, Ontario, 1949

Interest is being focused on the new Homes for the Aged Act of 1949 (Ontario). This piece of legislation provides, in Section 11, a statement of the classes of persons who may be admitted to a home for the aged. These classes are:

(a) Anyone over the age of 60 years who is incapable of supporting himself or unable to care properly for himself.

(b) Anyone who is mentally incompetent or ineligible for committal to an institution under the Mental Hospitals Act who requires care, supervision, and control for his protection.

(c) Anyone over the age of 60 years who is confined to bed but does not require care in a public hospital or hospital for the incurables.

(d) Anyone under the age of 60 years who, because of special circumstances, cannot be cared for adequately elsewhere when his admission has been approved by the Minister.

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In every community there are patients, young and old, whose dietary habits we are trying to change. It does take time to individualize one's teaching but, by and large, progress will be slow and the results discouraging until we recognize the fact that eating habits are an expression of a pattern of living and that any attempt at change must be built upon a knowledge of the patient's economic and social background.

No one has a greater sphere of influence in improving dietary habits, whether it be in the field of special diets or normal everyday eating, than the nurse who has a working knowledge of nutrition and is willing to take the time and effort to know the human factors controlling the daily life of her patient. —*Public Health Nursing*

The Community Needs Old People

JEAN GOOD, B.A.

Average reading time — 14 min. 24 sec.

WE ARE LIVING in an era distinguished by two new and important features—atomic energy and great-grandparents. Both have great constructive possibilities.

Because old people have had to accept arbitrary retirement at a chronological age, pensions inadequate for their needs, and institutions which segregate them, and often remove them from their community and their friends, does not mean that such conditions need continue. We have followed a wasteful and cruel course long enough and are due for a right-about-face. Over 60's are the people who have worked and planned and carried the national life along during the first half of the 20th century. They claim the right to participate in the life of the community and to continue to be creatively active.

Although there is a higher proportion of old people in the population of towns and rural areas, *their* problems are not nearly so acute as they are in cities. One of the reasons for this is that it is easier to keep busy on the farm and in small towns. Another reason is that rentals are much more reasonable. Still another is that the pace is more leisurely. As we move from an agricultural to an industrial economy, human problems stand out.

Dr. Stieglitz, a Washington physician, who wrote that excellent book, "The Second Forty Years," states that he believes that the measure of a nation's culture is in direct proportion to its respect for its old people. He points out how China and India value and honor the wisdom and judgment of old age. In Europe there is recognition of the capabilities of old people. Even in the United States, where the emphasis is all on youth, they have as their national figure a grey-bearded old man—Uncle Sam. Dr. Stieglitz thinks that Buster Brown would be a more suitable symbol. (If you know who Buster Brown is, you are definitely dated!)

Mrs. Good is secretary of the Division on Old Age with the Welfare Council of Toronto and District.

THE ROAD WE HAVE COME

Old age pensions were first paid in Ontario in 1929 and the payment of them was almost coincidental with the stock market crash. A sum of $20 per month was made available to people over 70 years of age in certain circumstances. At the same time employment became very scarce. We went through the lean 30's with jobs going to heads of young families and older people being pushed out of business and industry. Pension schemes with an arbitrary retirement age were sold by insurance companies and the Federal Department of Labor. Then came the war, with the young men away and important work to be done. The *old* men of 45 and 65 and 85 were called back to do a job and came down off the shelf. They proved their worth but again they are out and this time partly because of the pension scheme where the employer has to pay a larger contribution for the older men whom he takes into his employ. Whatever kind of allowance comes from the work of the Parliamentary Committee on social security for old age it must do nothing to discourage the industry of old people who wish to continue to make their contribution to life. In England if an old person who has reached pensionable age wants to continue working he gets a higher pension when he does retire.

In the Women's Patriotic League Workroom in Toronto, a workshop for elderly women, we have an excellent example of the benefits of sheltered employment. The League is a place where 45 elderly women do household mending, make quilts, knit garments,

make pyjamas and nightgowns, mend old lace, and turn the collars on men's shirts. The work is brought to them and collected by the people who need to have it done. The elderly employees are paid for their work and part of the return is a substantial noon meal. It may be significant that in over 30 years only one employee has had to be admitted to an Ontario hospital. Work is essential to the well-being of all people.

The new factor of having such a high proportion of old people in the population influenced Lord Nuffield to establish a foundation in Great Britain which made possible a complete survey of the income, housing, and living conditions, homes and institutions, recreation, and the employment of old people. The Survey Committee came up with some very interesting findings, some of which were:

1. The vast majority of the aged are independent.
2. Only 5 per cent of old people live in special dwellings.
3. There is need of better provision for the long-term sick.
4. Several thousand more small homes for 30 to 35 residents were needed.
5. Employment is beneficial and necessary.
6. Need for further inquiry and for a balanced policy based on well-informed public opinion.

We Canadians have need for further inquiry and for a balanced policy, based on well-informed public opinion too. This has to do with *all* old people—not just poor old people or sick and infirm old people—but with your parents and my aunts and uncles and the next-door neighbor and the people you and I are going to become a few years hence.

Dr. Charles Courtenay, when he was "an old fellow of 87 and half-blind," as he described himself, published a book, "On Growing Old Gracefully." The dedication of the book reads:

To All my Friends Everywhere

To the aged —Who know that they are old.

To the aging —who only suspect it.

To the young—who never think of it.

Because of the over-emphasis on youth, no one wants to be thought old. Old age is 10 years older than anyone in any company of people. It is what happens to other people. We are not going to become gracious and gentle and considerate and resourceful old people, unless we begin doing something about it now. If we can laugh a little about it, it may help us to accept old age as a normal stage of life towards which we are all proceeding. Think of it as being the era of the four B's—*Baldness, Bulges, Bifocals and Bridges!*

One of the best ways to get used to the idea of old age is to read some good books on the subject. I have already mentioned two and to them I should like to add three others—"Aging Successfully" by George Lawton, "You are Younger Than You Think" by Dr. Martin Gumpert, and "Age is Opportunity," published by the National Old People's Welfare Committee, London, Eng.

When you have read these books you are bound to want to get a group together to do something about old age—your own or other people's. This business of old age offers a wonderful opportunity for cooperative effort, which is workable in villages, towns, or cities. Nurses should not attempt it alone, neither should doctors, nor social workers, nor adult educationalists. It is something where we need each other and where teamwork is not only possible but essential. In your town, when you look about you for a team to consider old age, you may find that the interested people are the grocer, whose grandfather kept the same store, the priest, a school teacher, the relief officer, the president of a service club, a retired minister, the local member of Parliament, a rabbi, the superintendent of the hospital or county home. Be sure that there are some people over 60 years of age in the group. They know what it is all about. If there is a Welfare Council in your community, talk to the executive secretary about the formation of a committee on old age. If there is not a Welfare Council,

do some pioneering in community organization. When you get your community committee together, list what you have for old people, what is needed, where the gaps lie, and then tackle the most urgent problem.

Friendly Visiting

You may find that friendly visiting is one of the first needs. Loneliness is the greatest scourge of old age. It happens to rich and poor alike. There are many small everyday things that could be done to relieve the loneliness of elderly neighbors and friends. If you live in a small town, you might call for the mail, deliver it to your elderly friend, stop for a chat, and maybe write a letter to the son or daughter who lives out West.

The Toronto Red Cross Corps has a friendly visiting service whose volunteer visitors call regularly on their elderly friends, arrange automobile rides, provide handwork, teach hobbies, and plan for entertainment in the home of elderly home-bound people. Do not forget the county or municipal home when you are planning regular visits or special events. We need to know a great deal more about how people live in homes for old people. Get to know them as individuals and feel responsible for conditions in your own publicly-financed home.

Social Centres

The Second Mile Club, Toronto, is a social centre for elderly people. It is housed in a fine building purchased and renovated by the city of Toronto and rented to the Club for a dollar per year. It is a place where older people really belong, where they are part of a friendly group, and where they can meet to talk, cook meals, play games, make their own plans, sing, dance, and be understood and liked. They come there from attic rooms, from homes for the aged, from the homes of their relatives and from their own homes. One old lady who lives with her daughter said to the director, "My! I just look forward to the day I come here—and so does my daughter." A teen-age group in the community centre in York Township arranged a bus trip and all-day picnic to Niagara Falls for the elderly people of the community. It was such a pleasant experience for both groups that a special event each month is sponsored by the teen-age group for their elderly friends.

Several churches in Toronto have arranged for daily, weekly, or monthly get-togethers for the older people of the congregation and neighborhood. For the past three summers, the Neighborhood Workers' Association has arranged a delightful holiday for senior citizens at Illahee Lodge, Cobourg. In the summer of 1949, 166 elderly people enjoyed the beautiful location, the good food, and the opportunity of meeting new friends and having fun. A station wagon added greatly to the pleasure and excitement and made possible delightful picnics in the country.

Personal Services

In smaller communities, neighbors perform services, the responsibility for which in cities must sometimes be taken by organizations. A central bureau, where an old person may go to make inquiries about living accommodation, pensions, health matters, hospital care, is an urgent need. A skilful person in charge will discern those in need of special counselling services or of psychiatric care.

Living Arrangements

In spite of all the difficulties involved, the best place for an old person is his own home or with interested friends or relatives. In order to make this possible, visiting nurses and home aides are essential. There is need, too, for study as to how three and four generations can live happily under one roof. This may mean the development of a new type of living accommodation.

Until 1943, most people thought in terms of "Home for the Aged" in housing. The approach was almost wholly institutional and the idea of "customer satisfaction" in housing the elderly is still something which only the very thoughtful have considered. However, we now have the

Nuffield Report from England, "Birthdays Don't Count" from the New York State Joint Legislative Committee on the Problem of the Aged, and "Social Denmark," published by the Social Department of Denmark, to give us some guidance. Furthermore, we have a few interesting developments in Canada which will bear study.

Let us bear in mind that the sick and well each require a different type of housing and a specialized type of care. A young architect with a special interest in old age, now studying planned communities in Europe, writes that "the Ministry of Health for Britain divides housing for old people into two simple categories—(1) housing for those who need space only and (2) housing for those who need *care* and space." From England, the United States, Sweden, Denmark, and Germany, we get the following summarization of the important factors in housing elderly people:

1. The old should not be segregated.
2. There must be a variety of accommodation provided.
3. The housing should be for groups of all incomes.

Here are some quotations from modern writers:

Projects for the elderly should be built as part of other public housing communities, with separate wings devoted to elderly exclusively. Under no circumstances should these projects be separated from other housing or be built on an institutional pattern.—CHARLES ABRAMS, *New School of Social Research*—article in "Birthdays Don't Count."

* * *

The importance of the smaller homes in the country should not be overlooked for they make it possible for the old people to remain in the district where they have spent their lives and near to their families and friends, all amenities which, to them, more than compensate for any short-comings there may be in respect to modern convenience.—SOCIAL DENMARK.

* * *

It is a mistake to plan old people's dwellings all together around a square as the comings and goings of their younger neighbors are a source of great interest to older people.—OLD PEOPLE'S WELFARE, England.

* * *

In the selection of a site for old people's dwellings, the first necessity is that they should be in a locality familiar to the persons they are designed to accommodate and within easy reach of their relatives and friends, convenient to shops, post office, bus stops, library, churches, and recreation. They should be located where the old people can look out on traffic. Smaller groups of houses for old people may be interspersed with houses for other age groups.—OLD PEOPLE, *Nuffield Report*.

* * *

To encourage the housing of old people within the community, there should be subsidization of home-builders who would add a one-room apartment with adequate plumbing and private entrance for letting to people over 60 years of age. This plan might be developed where building lots are broad and plentiful.—PAUL JOLIFFE, *Toronto*.

The Nuffield Committee agreed that all normal old people, who are no longer able to live an independent life, should be accommodated in small homes rather than large institutions. In Ontario we find ourselves in difficulty because of faulty legislation. The Homes for the Aged Act makes it compulsory for municipalities to have homes for old people and to this legislation are tied plans which are of an institutional type, although cottages are also included. This tends to segregate the old people from the community. The legislation provides that these homes should be governed by the elected representatives, the local county council, or city council. There is no place in this legislation for a board of citizens familiar with the needs of old people—their health and welfare—and the governing committee, therefore, lacks continuity of interest.

The Charitable Institutions Act provides that privately operated homes for old people, such as those operated by religious orders, church groups, boards of interested men and women, have to come up to standards

set by the Ontario Department of Welfare but no assistance is given them to reach these standards, except 10 cents per day per person.

The town of Burlington took advantage of its opportunities under the National Housing Act to build three apartment blocks containing two- and three-room apartments. Interested people, service clubs, etc., in the town provided one-third of the cost of the first unit and two-thirds was financed under N.H.A. The two-room apartments rent to single old people at $16 per month and the three-room apartments for elderly couples at $21 per month. The old people are delighted with the plan. They are living as part of the community in a familiar setting and the rent which they pay to the town will, over 49 years, repay the Federal Government loan.

Space and care for *sick* old people is another matter. Acutely ill old people find difficulty in being admitted to general hospitals because the experience of the hospitals is that once they are admitted any possibility for transfer out when they are better seems to vanish. It is evident that we need more hospitals for long-term illnesses. Where such a hospital is adjacent to or part of a general hospital, there is a much better opportunity for study and research and the facilities of the general hospital are available. There is also need for a nursing-home type of care. This is largely left to commercially-operated homes which are expensive and for which there are no enforceable standards. Persons for whom adequate facilities are almost wholly lacking include the mentally enfeebled. The need for provision of hospital care for them is entitled to serious consideration and action. Even in communities where a wide variety of types of care is provided, there is an urgent need for facilitating transfer between the various services.

While we emphasize the need for study and care in the old age situation, we should avoid being overprotective toward old people who must retain their independence and continue to be individuals. A friend of mine received a letter from an elderly aunt living in England. She wrote that her nieces and nephews had persuaded her to move from the big old family home where she had spent her life because they did not think that at her age she should be living alone. She reported that she had moved into smaller "digs" and ended by saying, and you can almost see the twinkle in her eye, "Some are born senile, some achieve senility, and others have senility thrust upon them."

Care of the Sick Aged in the Home

JESSIE A. WALLACE

Average reading time — 10 min. 24 sec.

SOME UNIQUE satisfactions await the nurse who provides nursing care for the sick aged in the home. To experience these satisfactions she must have unlimited patience and sympathy, keen powers of observation, wide imagination and, greatest of all, a fine sense of humor. She must recognize that aged patients are people and as such have a right to be different. They have established habits and ways of living that have meaning to them. They have fears, hopes, worries, aspirations, loves and hates just as any one of us has. Their illness will affect and be affected by the

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physical and emotional make-up of each person. Their illness cannot be separated and treated apart from the total individual. If we recognize these principles, we can readily understand that nursing care for the sick aged does not begin and end with a bed bath. Their physical needs, including nutrition, must be adequately provided for but so must their occupational and emotional needs.

Here the nurse must examine carefully her own attitudes. Good nursing care for any age, and particularly for the sick aged, is an art to be cultivated rather than a drudgery from which to escape. She must learn to work *with* the patient and not *for* him. If she puts forth the effort to dip down into her reservoir of patience, tact, understanding, humor, and practical psychology, she will be amazed at the depth of the resources she possesses. If she prefers to skim off the surface then she can never realize the intense satisfaction which can be her reward.

Before the patient can be adequately cared for, those at home must understand the need for and how to assist with that care. Present housing conditions may mean anything from a home with four generations living in it to the one room of a rooming-house with the husband and wife trying to meet the demands of a complicated society, including an irate landlady, and living in mortal fear of death separating them and leaving one helpless individual. In the home with four generations the illness of the great-grandmother must be understood by all—the housewife and her husband, who likely own the home and have struggled to make payments on it and to raise a family; their daughter who has married and, as she cannot control housing shortages, has remained in the home, bringing with her a husband and eventually a child. All these generations have resentments against the circumstances which force them to live together. They may also have fears of the illness suddenly thrust into their midst. All have desires and needs on varied levels which must be satisfied. The nurse, with the aid of the physician and available community resources, must assist in bringing about this understanding. She must inspire confidence in every member of the family so that each can and will make the right contribution to the necessary care.

The choice of the room to be occupied by the patient is important. Without too much disregard for individual rights, the warmest, brightest, and most convenient room is best. The provision of equipment, including a hospital bed, can often be arranged through a community loan cupboard. This may be under the Red Cross or a service club or community service clubs might be interested in joining together for such a project. If a hospital bed is not desirable or available, bed blocks to elevate the bed and a back-rest can be improvised by the family. The provision of simple, necessary home equipment, through the ingenuity of the family, develops within them a sense of accomplishment which few can understand if they have not experienced it.

In the actual bedside nursing care we have recently been hearing a great deal about *T.L.C.—Tender Loving Care*—an indefinable trait manifested in many ways which makes the patient glad you are his nurse. Dr. M. Cherkasky, Home Care Executive, Montefiore Hospital, New York City, states that this is a most important component of the treatment and rehabilitation of the chronically ill person. Many of our sick aged fall into this class. He feels that T.L.C. can best be administered in the midst of familiar surroundings.

The nurse who gives bedside care in the home is part of the patient's illness experience. Her relationship is professional and intimate and exceedingly important to the patient. The care she gives, although routine to her, is evidence to him of her interest and of his value as an individual. She should extend to him reassurance and kindliness. He may be tardy in responding to her for the tempo of the aged is slow. Here, patience is indeed a virtue. Where resentment and irritation is shown, it is rarely against the

nurse as an individual but towards the whole illness with all its limitations.

In giving nursing care, we must remember that impaired circulation, providing inadequate nourishment for the skin, is a factor in most cases of illness among the aged. This necessitates careful attention to good skin care. Keeping the patient clean and dry is a "must." Frequent changes of position and proper support prevents excessive pressure on any one area. At the same time good massage, with back rub and powder, stimulates the remaining powers of circulation to those areas where pressure is greatest. Powdering the bed-pan to avoid sticking may prevent a broken skin area. Good oral hygiene must be demonstrated. It can be the responsibility of the family as can care of the hair, including shampooing. Proper elimination must be the joint responsibility of the nurse and the family.

The importance of the prevention of deformities in the sick aged cannot be over-emphasized. Every day we see pathetic results of crippling deformities, many of which could have been prevented. A knowledge of correct body alignment is fundamental to preventing deformities in the aged. Joint stiffness and muscular weakness often appear with alarming rapidity. They hamper the progress and rehabilitation of the aged patient when the acute stage subsides. Again the ingenuity of the family, plus the use of a loan cupboard, can provide bed-boards to prevent sagging of the mattress, which is so detrimental to good bed posture; foot-boards to prevent foot-drop; sand-bags and rolled towels to prevent undue rotation in fractures and cerebral hemorrhage patients; and proper placing of pillows of suitable size to assure comfort for the patient. The use of all these things can assist in the application of the principles of correct body alignment. The danger of contraction by the use of large soft pillows under the knees is a hazard of which all nurses should be aware. Under medical direction, the active and passive exercises should be established early to prevent further loss of function. Here the physician, the patient, the family, and the nurse must work as a team if maximum results are to be obtained and a feeling of dependence minimized.

The supervision of the nutrition of the sick aged opens a wide field for cooperation between the nurse and the family as well as the patient. Nutrition exerts an influence over every person at every age. Particularly important are the cumulative effects over the years and the pattern of food habits established. The person who eats a slice of toast and jam for breakfast and washes it down with a cup of tea, opens a can of soup for lunch and maybe provides one vegetable and a sausage, with pastry for dessert at dinner, has failed to build both maximum health and acceptable food habits. The nurse must have a wide knowledge of the basic nutritional needs of her patient and interpret these in simple language to both patient and family. Suggestions and recipes which satisfy these needs should be made available.

Interest in the nutritional requirements of the patient may be stimulated by a weekly recording of all food consumed. This may be done by the patient, if he is able, or by a member of the family. Together with the nurse, this can be evaluated and then compared with an accepted standard of requirements. It is a well established fact that attempting to change the food habits of any individual is one of the most difficult tasks one can assume. To accomplish this change, the nurse must stimulate an interest in adequate nutrition within the family unit. This may well call for the combination of the "strategy of the diplomat, the sternness of the dictator, and the psychology of the salesman."

It has been indicated on several occasions that the aged require a high protein diet. In a County Home near Cleveland, where there were a number of supposedly incurable people, the nutritionists experimented with a high protein diet. They served hot meat

twice a day and increased the intake of milk. This resulted in a high percentage of the patients returning to the community. Some even returned to employment. The increase of calcium in the old age diet might help to prevent some of the fractures we see in this group. The need for additional vitamin C and iron has also been recognized. One thing which must be avoided in serving food for the aged is monotony. Give them surprises—don't have them tell what day it is by the food on their tray.

The nurse in the home must be equipped with the understanding and knowledge to cope with emotional needs accompanying the oldster's illness. She may know very well how to prepare for a treatment or how to do a dressing with perfect technique but does she know how or bother to relieve the fear of the treatment, the apprehension of undue exposure, the resentment against the whole illness with a future which, to the patient, offers nothing but uselessness, bed, and death? In caring for the aged, regardless of our knowledge of prognosis, we must, in some way, capture hope and transfer that hope to the patient. The nurse's own attitude is quickly sensed and accepted by her patient. I am not referring to false hope, for that could be as detrimental to the morale of the patient as no hope. This hopeful attitude must be accompanied by one that is helpful if the patient is to develop a will to live.

The nurse brings into the home that priceless contact with the great outside world which has been denied the sick person. Maybe he is interested in hockey—so you know the latest score of his favorite team. Maybe it is the Gospel singer—so you know his favorite hymn. He has his favorite radio programs and you can give him that precious feeling of importance by discussing these with him and at the same time skilfully and unassumingly guiding his listening to some of the better radio programs as well as the lighter ones. The patient's morale cannot be maintained only by things done for him but must also include things he can do for himself. Any part of his care, regardless of how small it may be, for which he is capable of assuming responsibility should be assigned to him.

Here the occupational worker can be introduced. If such a worker is not available, the nurse should press the family into service under her supervision and develop a plan of activity in which the patient is the important centre. It may be knitting, jig-saw puzzles, thinking up words for a cross-word puzzle, or any one of many other forms of occupation. Monotony is one of the greatest hazards for the sick aged and the nurse is sometimes taxed to the limit of her imagination to prevent this. A film shown in the patient's room is a thrill he never forgets. Here in Toronto we are exceedingly fortunate in having the Variety Club which provides a major place on the program of its activities for bringing films to the shut-ins. Many of our sick aged get this service. Most aged people have a sense of need for religious satisfaction. The nurse can encourage this desire and facilitate arrangements for visits from the clergyman of his choice.

I have previously mentioned the need for teamwork in the care of the sick aged in the home. I omitted one important worker on that team—the trained certified nursing assistant. There is a definite place for her. The registered nurse may well share with the assistant the responsibility for some of the care of the convalescent or chronically ill patient. Together with the patient and family they can lay plans for the future. It has been said that " 'together' is one of the most inspiring words in the English language—coming together is a beginning; keeping together is progress; working together is success." It would seem that this could well apply to the relationships being established between professional nurses and nursing assistants. Examining our own attitudes to the assistant, sharing responsibilities with her, and providing planned supervision should lead to better care and greater satisfaction.

Sometimes I have wondered if we could achieve maximum care for sick

aged who are so eagerly discharged from the hospital, by coordinating the hospital service and the community service. This might be undertaken by a nurse who would be attached to a visiting nurse organization staff and who would prepare the family and the home before any patient could be discharged. Here we have this pathetic group of older people to whom we offer a lengthening span of life. What have we done to give them a fuller satisfaction in living those extra years with a maximum degree of health?

Truly, nursing the sick aged brings out the best in the nurse. Again I repeat that it requires skill, adaptability, keenness of perception, humor, ingenuity, imagination, and understanding. It gives comfort, satisfaction, and some peace of mind in the declining years of life. The understanding we bring to the task of caring for the sick aged will make the process of aging for each of us a more satisfying experience.

Problems of the Older Worker in Industry

B. Blanche Bishop

Average reading time — 8 min. 36 sec.

Modern society, with its accent on youth, has seemingly little time to devote to the problems of its senior citizens. Personal economies are the concern of all people, old or young, and gainful employment is one of the essentials for a satisfying foundation to this economic structure. Success or failure in securing and maintaining a job in our highly competitive industrial life with, in many cases, its demands for youthful employees, presents problems to older workers that are reflected in the life of the community at large. If the lengthening life span means more aging people in a labor market already surfeited, we must try to understand some of the implications of such a situation.

As a first step, let us try to assess the value that these older men and women have for industry. Usually they offer a background of experience and a sense of loyalty and responsibility to the employer. Generally they exhibit greater care in workmanship, thus reducing the risk of on-the-job accidents. The absentee rate is usually lower among older workers and, as there is but little incentive to change occupations, labor turnover is at a minimum.

Offsetting these features, we know that advancing years bring with them an increasing proneness to sickness and that a longer period of time is required for recovery from an illness or accident. There is almost invariably a gradual dwindling of strength and energy so that heavy tasks, once a routine part of the working day, are now at times impossible. Nevertheless, almost every industry, and particularly those engaged in light manufacturing, has a place for the aging employee. He must not be cast upon the economic scrap-heap merely because he is unable to maintain the pace set by younger colleagues.

It is impossible to arrive at any mass solution to the problem because oldsters, like ourselves, have a variety of backgrounds, personalities, and needs that cannot be made to fit into any one standard pattern. Increasing emphasis in the human relations field suggests that these differences merit consideration so that, while we may strive towards an overall solution, it must take cognizance of those intangible qualities in each individual best described as "human dignity."

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A practical approach to the problem should be directed towards helping the individual realize and acknowledge that advancing years bring their own changes. There should be some preparation, both mental and physical, for the psychological and physiological changes that are inherent and unavoidable. A counselling and guidance service, preferably under the supervision of the medical director or personnel officer, may help to give the older worker the understanding necessary for acceptance of age's limitations. Such a counselling service may help to allay those feelings of insecurity, mistrust, and suspicion that are contingent on impaired mental health.

The next step would seem to be to conserve the skill and craftsmanship an older employee has acquired through years of experience. His services may be used in teaching new untrained helpers and initiating them into the job. Inspection work, usually less strenuous but nonetheless essential, may prove an outlet for his knowledge and dexterity. This, together with transfer to some less-exacting job, implies a certain amount of re-training but an older person, familiar with the company policy, usually requires less training than a new employee. For those less skilled, jobs such as caretaking, janitor work, and elevator operating generally find age no handicap.

Another cause of concern to this older group is compulsory retirement at a fixed age. Ideally, no one should retire until he is ready and willing to do so but realism dictates that some thought must be given to this subject since many companies have an inflexible rule calling for retirement at a definite age. Many men, perhaps fewer women, actually dread the day of retirement. To them it is synonymous with withdrawal from life. Where this attitude obtains, all too often the pensioner dies within a few months of quitting work. Organically there may be no reason for his death but, through a sense of frustration and the belief that he is useless and unwanted, he loses the will to live. There is evidence that where some other interest has been substituted for the daily work routine (for it is apparent that an organism geared to a certain schedule for 30 or 40 years cannot suddenly be placed *in vacuo* without disastrous results) leisure life does afford the satisfaction it should. Accustomed as they are to a "work and earn" culture, many aging workers find difficulty in accepting the idea that leisure time and recreation require careful planning. Some companies help initiate the pensioner into his new routine by allowing him to return to his old job one or two days each week.

The counselling service previously mentioned can do much to help the individual realize the importance of leisure time planned around a constructive program. This will mean that his new routine will be meaningful and enjoyable, rather than a dull succession of uninteresting days. The preparation for retirement should, of course, be made several years before the actual day of leaving work. It has been well said that how one spends time in the last 30 years of life is determined in the first 30. The industrial nurse can help the older employee plan for retirement by interpreting existing community facilities for constructive off-the-job activities and encouraging him to make use of them. Men and women with an aptitude for community service should be encouraged to establish contacts with some local agency, with a view to future volunteer work. Others may find interests in hobbies and crafts. These often prove an added source of income should the pension require to be supplemented. Whether his interest lies in these things or adult education classes, community projects or study groups, the older worker should be encouraged to plan around them for his new leisure time. The industrial nurse's enthusiasm may be the necessary influence needed to foster his interest. She may help him realize that age is never a barrier to learning—we can learn anything we *want* to learn at any age.

As well as encouraging him to develop habits conducive to sound

mental health, the industrial nurse may guide the older employee towards optimum physical health. The value of regular medical examinations should be carefully interpreted, for they are the means by which the physician may detect early signs of incipient disease. Treatment to prevent it becoming a chronic or disabling illness may be suggested. As the over-40 age group are subject to the so-called degenerative diseases, health education should be directed towards a simple explanation of what these conditions entail. If indicated, some adjustment in daily routine may be necessary and the nurse can help the individual plan a new pattern of living.

So far we have been thinking in terms of the Canadian scene but the same problems arise in the United States to an even greater extent. So important does the situation appear that a study of the entire older worker question was undertaken by the New York State Joint Legislative Committee on Problems of the Aging. Part of this study consisted of a campaign to interest employers in hiring senior citizens. It was found possible to place only 1 in 10 in jobs that contributed to national production and at the same time provided the men and women with the self-respect that comes with self-support. Out of this study, certain recommendations were made, suggesting that permanent committees (composed of industrialists, representatives of labor, government, private organizations, and major commercial interests) should seek out job possibilities in each of their respective communities. Contacts would be provided by trade associations, labor unions, and similar bodies. Further, it was felt that there should be a constant campaign to publicize the value of the services of older workers, stressing their greater loyalty, conscientiousness, and regularity.

The committee proposed a counselling service for advice and assistance of unemployed older citizens to utilize past training and present capacities. In some instances re-training might be advantageous. It was felt that this should rank in importance with vocational training for the young. Employers should be encouraged to assess jobs in terms of mental and physical requirements in order that older applicants would not be automatically barred should a vacancy occur for which their capabilities would be adequate. The committee also considered the question of pension plans. The consensus was that the present schemes need revision so that a man of 40 years of age might change his employment without loss of pension rights.

There seems to be some relation between the report of this Legislative Committee and an account of a plan undertaken by a firm in Walkerville, Ont., although the relationship may be coincidental. In an article published in the September, 1949, issue of *Industrial Medicine and Surgery*, Dr. R. B. Robson, medical director of General Motors of Canada, described a series of 15 lectures given through the extension department of the University of Michigan. The lectures, attended by some senior employees of General Motors, dealt with the problems associated with old age, centring around such subjects as the need for financial security, physical health, psychological changes and mental health, leisure-time activities and the question of living arrangements, with an understanding interpretation of the irritations expected when oldsters and youngsters share the same home. Results were excellent. Those employees who had attended the lectures formed a nucleus committee to relay the information to fellow-workers over 55 and their wives. The enthusiastic response demonstrated the latent interest men and women have in the subject of aging. Similar classes might prove of value in other industries and contribute materially to the needs of those who have progressed along the road of life.

In dealing with the problems of the middle-aged group, one cannot disregard the very serious plight of those who find themselves unemployed. There is an urgency, a desperation about such a situation which many

of us cannot realize but which has its effect not only on the individual, but upon the economic welfare of the community at large. Increasing concern has been expressed at the inability of employment officials to place these older experienced workers in suitable jobs and the reluctance of employers to add them to their payroll. The situation demands serious thought. Sponsored by the National Employment Service, Dr. W. G. Scott has established a counselling service for senior citizens in Toronto and work is now underway to extend the facilities to other centres in the province. Possibly the recommendations of the New York State Joint Legislative Committee, which I have just cited, may be of help in formulating a guide to solving the problems of the out-of-work adult.

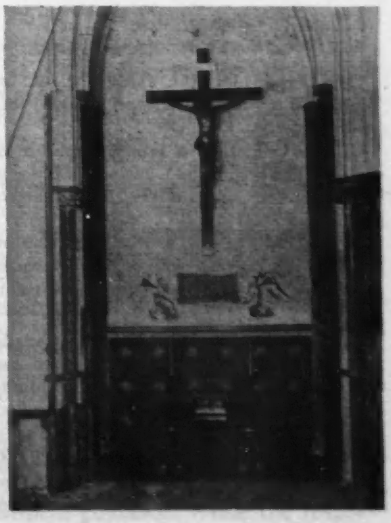
It is a problem that was almost unknown to previous generations with their preponderance of young people but it is becoming increasingly important in our own society. It is impossible to present any simple solution. One thing stands out clearly—the problem will undoubtedly increase in severity so long as the increase in the life span continues. Dr. Edward L. Bortz, past president of the American Medical Association, summed it up when he said, "The society which fosters research to save human life cannot escape the responsibility for the life thus extended."

To Commemorate an Untold Story

A beautifully illustrated, concisely written booklet, describing the Nurses' War Memorial Chapel in Westminster Abbey and its various appointments, is now available to Canadian nurses, through contributions to the British Commonwealth and Empire Nurses War Memorial Fund. A memento to be cherished, this booklet will be mailed to any nurse who makes a contribution of 2/6 or more to the Fund. All donations should be addressed in care of the Fund to *Dorset House, Stamford St., London S.E. 1, England.*

Launched under the egis of the *Nursing Mirror*, which has borne all administrative expenses for the Fund, in less than five years the Fund has reached the impressive sum of over £77,000. The Council administering the Fund had two objectives. The opening of the Memorial Chapel was the first, now accomplished. The second object was the awarding of post-graduate travelling scholarships to nurses. The first eight War Memorial Scholars were chosen in 1950.

Many Canadian nurses were present at the ceremonies when the Chapel was commemorated on November 2, 1950. Upper Islip Chapel, which has been allocated to the nurses by the Dean and Chapter of the Abbey, is in the North Ambulatory of the Abbey, near the North Transept. Until its opening by Her Majesty, Queen Elizabeth, who is patron of the Fund, and the dedication of its new furnishings by the Dean of Westminster, this Chapel had not been in use for hundreds of years. The Chapel is quite small, but beautifully proportioned, and from it there is a fine view of the Abbey.



Nursing Mirror Photo

Nursing Mirror Photo

The design for the furnishing of the Nurses' War Memorial Chapel included four main subjects:

1. The Crucifix is a bronze duplicate of the very fine original by Giovanni da Bologna which is in the Church of the SS. Annunziata at Florence.

2. The old Purbeck marble tomb slab on the four gilt bronze colonnettes is known to have been part of Abbot Islip's monument. On it is placed the new bronze casket, containing the Roll of Honor in which are inscribed the names of the nurses, midwives, and auxiliaries who died in World War II, with a note signed by Her Majesty, recording

This Chapel is dedicated to the lasting honor of all the men and women from the United Kingdom and all parts of the British Commonwealth and Empire who gave their lives in the Second World War 1939-1945 whilst caring for the sick and wounded. The Roll of Honor here displayed records their names to the number of 3,076.

The book is bound in blue leather tooled in gold, lettered in black with blue capitals. On either side of the casket is a bronze candlestick given by the Queen. Directly under the cross, two angels support a framed tablet on which is a quotation from St. Paul's Epistle to the Philippians:

He humbled Himself, and became obedient unto death, even the death of the cross. Wherefore God also hath highly exalted Him, and given Him a name which is above every name: that at the name of Jesus every knee should bow: and every tongue should confess that Jesus Christ is Lord to the glory of God the Father.

3. The seats and kneeling desk are of polished oak.

4. The Memorial Window, designed by Mr. Hugh Easton, fills almost the whole of one side of the Chapel. The principal subject is the representation of the Madonna carrying the Christ Child who, looking below towards the kneeling figure of a nurse, raises His right hand in blessing. Above the nurse is St. Luke, the beloved physician. In the lower part of the window are placed the badges of the Nursing Services, the arms of the Dominions, and the names of the Colonies from which nurses came to serve in the war.

In the tracery is the lamp of Florence Nightingale, placed upon a Red Cross and encircled by the Crown of Thorns which symbolizes the sacrifices of the nurses who gave their lives.

Work for the blind was begun in Canada in 1861 when the Grey Nuns founded the Nazareth Institution for the Blind in Montreal. This school is still functioning. The first Braille library was started in 1906. Today this library, which has grown to 20,000 volumes, has as widely diversified an assortment of books as a public library. A smaller number of books are also available in Moon type—embossed type of the printed letter—for older persons who have been unable to learn Braille. The popularity of the recorded or "talking" book has increased enormously in the past few years. Each month 30,000 of these records are circulated through the C.N.I.B. library.

—Canadian Welfare

Public Health Nursing

Opportunities and Responsibilities of the Nurse in Industry

GLADYS A. JAHNCKE

Average reading time — 20 min. 48 sec.

RESPONSIBILITIES

IN THE consideration of, and preparation for this paper, I have purposely regarded these two distinct topics — opportunities and responsibilities—in their reverse order. I have done so because this is the sequence in which they are generally regarded. Responsibility is synonymous with duty and means that one is answerable to a trust. Opportunity, on the other hand, in its strict sense means a certain action which has the probability of success at a certain time or which is advantageous or gratifying to the individual. Personal considerations, then, may enter into the realm of opportunities but nurses, belonging to a profession devoted in service to others, should consider first the responsibilities imposed.

Industrial nursing has come a long way from its inception in 1896 to the present day. It has passed from its original design of providing first aid to today's all-inclusive nursing practices which run the gamut of our professional services. Today's growth and development has been reached through years of struggle and effort—effort on the part of management, labor, physicians, and nurses. Nurses recognize with humility the progress of industrial nursing, which has been made largely through our own efforts.

We also recognize that we have a long way to go to have all industrial nursing services measure up to recognized acceptable practices. In my delineation the industrial nurse has a responsibility to her patient, the employee, to the employer, the medical profession, the nursing profession, and to the community in which she lives and works. These responsibilities can be broken down into three categories:

1. Nursing practices in relation to medical and nursing professional standards.
2. The nurses' responsibilities to her employer and employee.
3. The nurses' responsibility in the plant industrial hygiene program which affects and is affected by the community.

MEDICAL AND NURSING PROFESSIONAL STANDARDS

It is a fundamental principle of all nursing that the care of patients should be directed by licensed physicians. The lack of medical direction has been a source of concern in the industrial nursing field for a good many years. It is difficult to fathom how the practice of nursing service in industry without medical guidance originated. It is more difficult to believe that this problem continues to exist. On the basis of professional training and legal practice physicians diagnose and treat patients. According to the same criteria nurses give care to patients conforming strictly to the medical treatment prescribed. Yet some industrial nurses continue to carry on professional services without medical guidance. While the responsibility for this adverse practice must

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be shared by nurses, physicians, and management, the professional personnel must bear the brunt, for both physicians and nurses know that we are failing to meet the standards of our professions.

HER EMPLOYER AND EMPLOYEE

The industrial nurse must have a sound knowledge of the scope of industrial nursing services and recognize how she fits into such a program. It is timely, perhaps, to define industrial nursing and to enumerate the objectives of such a service in order that we can proceed to discuss its scope.

Industrial nursing may be defined as the practice of the art and science of nursing in industry to meet the needs of the worker. This practice includes:

1. Prompt remedial care of the ill and injured.
2. Assistance with accident prevention and safety education.
3. Assistance with the development and maintenance of the highest potential level of health and efficiency for the worker.

The objectives of industrial nursing, as I have defined them previously in an article in the *American Journal of Nursing*, October, 1945, are:

1. To give good nursing service under the direction and written standing orders of the industrial physician.
2. To help maintain and improve the health and welfare of the industrial worker, to increase his efficiency and concurrently his production. Working toward this goal the industrial nurse must see the need for, and the value of, the plant medical department's functioning in conjunction with all departments in the plant and with all available community resources.
3. To work with the safety department on the safety education and the accident prevention programs for the worker.
4. To reduce loss of time due to occupational and non-occupational illnesses and injuries.

The industrial nurse, then, who confines her services to emergency work only is not proving her real value. The importance of nursing skills in the care of the ill and injured cannot be minimized but the industrial nurse must do more than exercise this duty. "An industrial medical department," according to Dr. Wm. J. Fulton, "manned only to take care of direct dispensary service, is at best realizing 40 per cent of its potential value to industry."[3]

We know that about 90 per cent of absenteeism in industry from illness and injury is due to what happens to the man off the job. These figures point up the need. The industrial nurse must be alert to the importance of including health and safety education in her health services. She must be watchful for ways and means of supporting and promoting the program which is best for both employer and employee who may not always see eye to eye with professional personnel. Some employers continue to be of the opinion that what happens to the man off the job is of no concern to industry. Some groups of employees, because of unfortunate past experiences, may look upon any new health service with suspicion lest discriminatory action be the real motive for the development.

Better integrated health services can be developed and are found when nursing practices are applied to fundamental principles. Let me discuss some principles, which apply to the practice of industrial nursing:

1. *Only well-trained nurses be employed.* In the earlier days nursing was limited to skills and techniques to care for the ill and injured. The nurse with just her basic training was sufficiently qualified. Today, nursing service extends far beyond these limits and includes health teaching, counselling, and a variety of other skills. There are definite qualifications set up to guide the employer in selecting nursing personnel for his health services.

2. *Teaching should be considered as important a part of the work as the care of the sick.* Safety education and accident prevention programs have reduced numbers of accidents greatly—a far cry from the days of caring for the injured after the accident had occurred.

Illnesses, as well as accidents, can be

greatly reduced through health education. The nurse will assume her role in the program of health education as outlined by the physician. If the physician is employed on a part-time basis and his interests are confined to the curative aspects of the program, the nurse, with the knowledge and approval of the medical director, should be permitted to carry on health education work.

As a teacher of health the industrial nurse will impart knowledge of the principles of healthful living in terms which the worker understands, accepts, and which create in him the desire to practice them in the plant and in his home life. The nurse must recognize the psychological time for this instruction. It is usually propitious to teach health and safety to the employee while giving him care for an illness or injury but the nurse must, of course, always use good judgment about her timing. The patient may be particularly distraught or alarmed following an injury and the nurse must be sensitive to her patient's needs if her teaching is to be most valuable.

The approach to her worker is that of nurse, teacher, and counsellor. To be effective it should be based on courtesy, consideration, tact, interest, understanding, and insight. She should be guided by the knowledge of her patient's background, experience, and attitude. In order that the nurse may help the worker understand and meet the problems of his health and well-being, she must have a thorough understanding of:

HEALTH AND WELFARE FACTORS—his previous health history, general health habits, attitude toward health, and the work environment that may affect his health status.

SOCIAL FACTORS—which include his nationality and cultural patterns of the family, and education.

ENVIRONMENTAL FACTORS—pertaining to problems in relation to his home, sanitation, and recreational facilities.

PSYCHOLOGICAL FACTORS—to determine the relationships with his coworkers, representatives of plant management, with members of his own family; his emotional reactions and attitudes toward illness, injuries, and family responsibilities.

ECONOMIC FACTORS—which relate to his employment, income, and financial responsibilities.

The nurse's best service is given to the employee when she carefully evaluates her workers' problems through the above factors and counsels in accordance with the findings, scientific knowledge, and through cooperation with all available services in the plant and community.

3. *The rules of professional etiquette should be observed.* Much has already been said in regard to this principle. The responsibilities for diagnosing and prescribing are medical and anything beyond first aid treatment in an emergency, without medical supervision, is a violation of the Medical Practice Act. This does not imply that the nurse can do nothing in the care of the sick and injured without the presence of a physician. By employing qualified nurses the physician can delegate responsibilities.

4. *Cooperation should be recognized as of primary importance.* The health service is not and should not be an isolated one within the plant nor can it be independent of other health and welfare services in the community if the best care is to be provided for the industrial workers. The nurse helps to develop cooperative working relationships with all departments in the plant and assists in integrating the work of all. Since the health and well-being of the employee is inseparable from the health of the community the industrial nurse's responsibilities are directly influenced by community health and welfare problems and programs.

5. *There should be no interference with the religious views of the patients.* The employee should be given due understanding and consideration of his religious observances regardless of how much at variance they may be with the nurse's own religious views.

6. *Suitable and accurate records should be kept.* Good records are indispensable tools in giving good health services. To be valuable from a legal standpoint they must be accurate and intelligible. The method of recording is extremely important. In describing an illness or an accident the worker's statement must be recorded verbatim.

A good record is valuable to the employee for it makes available evidence of the nature of the injury: when, where,

and how it occurred. A record provides a means for guidance and the health counselling of employees. A chronological health record, of the worker, as he is seen in the medical department, for various reasons helps to give the personnel of the medical department a picture of his health and welfare needs.

A good record also protects the employer against unjustifiable claims. Analysis of records will permit a study of the health service needs of the employee group as a whole; wherein the services are meeting the needs, failing to meet them, or where they can be improved. A good report of services rendered can be produced only from good records.

7. *Service should be available to everyone.* Usually financed by the employer but sometimes by the employees, all employees should be encouraged to use them. There should be no note of charity in connection with the practice.

8. *Adequate provision should be made for supervision of the nurse's work.* Where there is a medical director, the nurse presumably will be guided by the policies which he has approved. On many occasions she may take her nursing problems to him for discussion and assistance. It is expected, too, that the medical director will look to the nurse for ways in which her services can be made more effective. For this assistance the nurse will look to others whose background will enable them to guide her. On large industrial nursing staffs there is a supervisor to whom the individual nurse can look for help. Some large organizations have consultant nurses to whom the individual nurse may turn for assistance. Most of the State Department of Health agencies and some local (county and/or city) now offer consultant services to nurses in individual plants. In an industry with a large nursing staff, exchange of professional ideas and stimulation is provided through staff conferences. The nurse who works alone in the field has a problem in this regard. She may, of course, seek consultation services and can benefit from participation in her professional organizations. She should be encouraged to attend local, regional and national organization meetings.

9. *The daily working hours of nurses should be limited to the end that good work may be done and they themselves kept physically well.* Suffice to say that good nursing care requires that the nurse herself be in good physical and mental condition and retains her enthusiasm so necessary to carry on her work.

In summary, I will enumerate the recommended practices for nurses in industry and which apply to the principles just reviewed:

1. Assist with medical examinations.
2. Participate in health education programs.
3. Assist with safety education and accident prevention.
4. Assist with plant sanitation.
5. Participate in welfare activities.
6. Maintain good records and reports.
7. Seek and/or give nursing supervision.
8. When feasible and advisable and without duplication of services of agencies, provide home nursing service and, aside from this service, confine her duties to the medical department.
9. Become authorized first aid and home nursing instructors.
10. Attain the qualifications recommended for industrial nurses.
11. Maintain affiliation with the professional organizations.
12. Encourage job analysis to depict the responsibilities in the particular position in order that salaries may be commensurate with the responsibilities involved.
13. Establish relations of the medical department with other departments and avenues for direct approach to an executive of the organization.

Industrial Hygiene Program and the Community

Every industrial nurse should make periodic visits through the plant. Without a thorough understanding of the operations and procedures the nurse cannot render a valuable nursing service. Without divulging any confidential information, she can discuss unsafe conditions and practices with the safety director. Her visits to various departments, her understanding of plant operations, and the hazards involved in the materials used, helps her to understand condi-

tions which are brought to her by her patients. She will be of little help to the employee who complains of headache, dizziness, and nausea if she has no idea of what the environment of the degreasing department in which he works may mean to his health. This phase of the nurse's responsibility cannot be over-emphasized and reaches even greater proportions where her medical director may be employed on a part-time basis. It is her responsibility to understand and to interpret to him conditions affecting employee's health which are brought to her attention during his absence. When he is away from the plant she should represent the medical department at meetings and conferences, for it is she who is in the position to interpret to management problems relating to health. The nurse, the engineer, and safety director should work together to help reduce hazards which cause illnesses and injuries.

Plant sanitation has a definite effect on the health and morale of the industrial worker and, when necessary, the industrial nurse must be able to offer recommendations for improvement.

The industrial nurse must recognize that the plant in which she works is an integral part of the community and, as such, affects and is affected by the community environment. It is said that the industrial physician is really a public health officer in the industry and the industrial nurse, as well as the physician, must be concerned not only with hazards of the plant but how they and the community problems are interrelated. They need to be mindful of industrial waste control, factory inspections and regulations, communicable disease control, safety codes and regulations, and vital statistics.

There should be direct working relationships with health and welfare agencies and departments of labor and industries. Since time lost from work due to illness and injuries is about eight times as great for non-occupational conditions as occupational, case-finding programs have proven invaluable to industrial employers and the community. The personnel of the industrial medical department can locate communicable and other types of disease and help the individuals to get treatment early. Case-finding and follow-up, which includes early rehabilitation, are most important phases of their work.

Opportunities

The opportunities for industrial nurses are so varied that an entire article could be devoted to this phase alone. In the foregoing, while opportunities as such were not enumerated, it is easy to discern many which would result by merely recognizing the manifold responsibilities.

There is ever-present the opportunity to provide improved nursing service to plants. Through efforts of our professional associations, standards of service are raised. Better qualified personnel are needed to meet these standards. Meeting the requirements continues to elevate the standards of the special field. To help meet the demands for better qualifications and services some universities have established courses and curricula of study for industrial nurses.

It is timely to say a word about part-time nursing services for smaller industries. Few employers have felt that full-time nursing service is economically sound where there are less than 500 employees. However, the number of employees is not the only criterion for establishing a nursing service. The hazard in a plant is a more important determining factor. Effective part-time nursing services have been developed in some areas to meet the needs of the smaller plants. These services have been provided through the utilization of established nursing agencies or through several plants sharing the services of one nurse. Part-time nursing services have pointed out the extent of service needed and have frequently led to the development of full-time nursing programs.

Time, patience, and education are required before many phases of health

service, which affect industrial nursing, are accepted. The industrial nurse must value these things if she is to make the best use of opportunities.

There is always the opportunity for the nurse to exercise leadership in helping to build healthier, stronger, and more efficient men and women in industry.

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In the Good Old Days

(The Canadian Nurse, February 1911)

"It is difficult to find nurses who have had experience in nursing poliomyelitis. Even physicians of years of practice are having their first case or are watching the progress of another's. It is only within recent years that the disease is known to be a transmissible one and only very recently that so much is being done to combat the paralysis following, for it is undoubtedly the early diagnosis with intelligent and early treatment that is giving such gratifying results."

* * *

A lengthy description appears of the establishment of a system of self-government for the pupils at Lady Stanley Institute, Ottawa. In writing of her motives for this radical departure from the old established pattern in schools of nursing, Mary Catton, superintendent, said:

"I became intensely interested in this system of control, not only because of its presenting a feature of progressiveness along the lines of discipline, but because of its departure from antiquated and morbid lines regarding what constitutes discipline, especially the discipline of training schools for nurses, which, though not resembling that of juvenile schools to the extent of flogging, possesses features that might better be eliminated in consideration of the fact that pupils in such a school must be of mature years, and possessing the highest motives, and to whose honor such an appeal as this system of self-government embodies must call forth the desired response."

Article 20 in their constitution states that the pupils shall use the following rallying-cry as their formal closing at the end of each monthly meeting:

"C.C.H.L.S.I.
We'll do right or we'll know why
For we are in honor bound
My! My! My!"

* * *

"The Board of the Royal Columbian Hospital, New Westminster, wishes to report their entire satisfaction with the management of the institution by the lady superintendent, efficiently and economically, as far as circumstances would permit, as well as the nursing staff who assisted the lady superintendent in the discharge of her duties."

* * *

"The Children's Hospital, Winnipeg, now in course of construction, is to be completed early in June so that the little sufferers may have its shelter and care in the hot months when epidemics work so much mischief."

* * * *

"Nurses have too long confined their attention to the work immediately at hand, leaving the advancement and improvement of their profession entirely out of their thoughts, expecting at some future time to have more leisure in which to broaden their activities. As a natural consequence, nurses have graduated from their schools and gone into the various avenues of the profession with a vision trained to see down this one avenue only and it was unusual that one abandoned the narrow, limited habits of the training school and took an interest in measures directed toward the usefulness of the profession . . . It is becoming obvious to training school authorities and, through them, to their pupils, that if the nursing profession is to become all that it may, the seeds of progress and broad vision must be implanted in the youngest pupil nurse and nurtured all through her training."

Institutional Nursing

It's Up to You!

MARY E. MACFARLAND

Average reading time — 3 min. 12 sec.

FOR SEVERAL years, under the caption of Institutional Nursing, articles have appeared in the *Journal* which have been interesting and informative. During the present biennium the committee desires to continue contributions to *The Canadian Nurse.* A request may be made of any member to write an article. Do say "yes" and let your thinking and writing appear in print. Nurses are now enjoying shorter hours of duty. This allows time for rest, relaxation, and study. How are we using the time formerly spent in work?

What topics affecting Institutional Nursing would you like to read about in the *Journal?* The objectives of the committee are to:

(a) Be concerned with—

(i) special problems of administration, supervision, and teaching in hospitals and schools of nursing;

(ii) nursing service, both graduate and undergraduate.

(b) Promote public interest in hospitals and schools of nursing.

(c) Promote a high standard of service.

(d) Establish a mutual understanding between nurses engaged in institutional nursing and other branches of the profession.

Suggestions towards achieving these goals and enlightening our large membership will be welcomed. Let us be keen in developing ideas towards progress and solutions to problems which are so vitally pressing our profession today.

Miss Macfarland, who is chairman of the Committee on Institutional Nursing of the Canadian Nurses' Association, is superintendent of nurses at the Toronto General Hospital.

Those who attended the Section meeting in Vancouver will recall the interesting program when there was discussion by a panel of experts on the question, "With the advanced scientific techniques and medications administered in nursing today, are we losing the all-important psychological nurse-patient relationships through spending less time at the bedside?" The summary was as follows:

> The concept of the nursing and health teams is very new and, with deeper understanding of each other's functions and with closer cooperation between the team members, the patient-nurse relationships and patient care should be better in the future than it had been before nursing the patient as a whole became our goal.

For some time teamwork has been successfully demonstrated between nurses and doctors. Presently, in hospitals with high census, early ambulation of patients, and changing emphasis on nursing, it is important that we develop the idea and display foresight towards utilizing the services of all members of the team to the best advantage. When we demonstrate within the nursing department that we are working as a team, patients will become aware of our teamship and accept with understanding the service provided.

The head nurse is the key person to administer the team. She expertly plans, assigns the duties, and is responsible for the smooth, efficient, and happy functioning of the service. The professional nurses, nursing assistants, and ward helpers should have clearly defined duties. By proper coordination and harmonious working together of the groups, nursing care of

good quality and appropriate in amount to meet the patients' needs will be rendered.

While the nursing shortage exists the use of auxiliary workers is indicated. They are not plentiful in supply and should be carefully selected. Let us be practical, rearrange our thinking, and share the care of patients among members of the team. It is suggested that better understanding and relationships are achieved when conferences are held and opportunities of planning afforded.

Today the effective use of nurses and increase in the supply of nursing personnel calls for cooperative effort. Each graduate nurse is a potential recruitment officer to attract trainees to nursing assistants' courses, students to schools of nursing, and graduate nurses to hospital staffs.

War Memorial Committee Meets Some Needs

During the biennium 1946-48, nurses in all parts of Canada cooperated loyally in raising money for the War Memorial Trust Fund. Some of the letters of appreciation for the libraries of nursing texts have already been published. Reference was made in the report of this committee for the last C.N.A. convention of some of the other gifts that had been sent overseas. Notable among these was the gift to German and Austrian nurses of 2,500 copies of the translation of "Nursing in Pictures" by Rothweiler. Numerous letters of appreciation have been received from instructors and groups of students:

Dear Canadian Nurses:

We are seven German nurses at Frankfurt on Main who want to make their nurse-examination in autumn. There are only some books to learn, and we are glad and grateful having got your "Krankenpflege in Bildern." Not only it is very instructive for us because there are many new and modern ideas, but also we are rejoiced in your nice German. We hope that our English doesn't disappoint you!

Many thanks and greetings from SCHWESTERN GERTRUD, CHRISTEL, ERIKA, SUSE, BARBARA, BRIGITTE, RENATE.

Another form of gift that has proven extremely popular with our colleagues was the teaching chart "Birth Atlas," supplied by the Maternity Centre Association of New York.

We sent 100 sets, altogether, to the nurses in Austria, Belgium, Denmark, Finland, Formosa, France, Germany, Greece, Holland, Italy, Japan, and Norway. It would be impossible to share all of the letters of appreciation with all the nurses of Canada. They will be filed at our National Office as a permanent record when the activities of the War Memorial Committee are concluded. Here are a few excerpts:

From Italy

We are deeply grateful to you for the splendid gift which is going to be of valuable help both to the instructor and to the student nurses . . .

From Finland

Your generous gift is of greatest value and we are happy to have this wonderful teaching material. How can we ever thank you for all you have done for us?

From Japan

You may well imagine, I am sure, how all our officials were pleased and thankful to see such wonderful charts. They will really be a lasting inspiration to our student nurses as well as staff nurses for higher nursing service . . . May I thank you heartily on behalf of all the nurses of Japan for such valuable gift.

From Greece

For years we were longing for such a chart, so we are delighted to have it and we wish to express to you our deep gratitude for your donation which will be a very precious teaching aid for us.

Next month we shall bring more news of how the donations of the Canadian nurses are helping to meet some of our colleagues' needs.

Aux Infirmières Canadiennes-Françaises

Lobotomie et Nursing

FERNANDE RIVERIN

(Suite de l'édition de janvier)

RÉHABILITATION

Dans les premiers jours suivant l'intervention, quand le malade aura repris à circuler librement, que tout sera rentré dans l'ordre au point de vue chirurgical, que les points seront enlevés, etc., que le malade ne se plaindra plus de céphalée, alors la garde-malade s'ingéniera à appliquer une ligne de conduite définie dans l'orientation nouvelle de notre lobotomisé. Ce programme sera dirigé sur une base de distractions, occupations de travaux simples et légers, de promenade à l'extérieur, de soirées de cinéma, etc.

Ces malades manifestent une extrême fatigue au début; c'est pourquoi on propose des tâches de courte durée. Ces travaux peuvent varier à l'infini: couper des compresses, plier et coller des enveloppes ou des boîtes de carton, rouler des bandages, etc. On leur confiera également certains travaux domestiques, leur en donner la responsabilité. Eviter la monotonie du travail à accomplir. Ne pas laisser le malade à lui-même car il sera porté à rêvasser, regarder par la fenêtre des heures entières. Toujours diriger son attention, provoquer son intérêt de mille et une manière. Dans cette ré-éducation ne pas omettre les soins personnels et les bonnes manières. N'oublions pas que tout doit avec beaucoup de tact lui être réappris. Il est reconnu que le lobotomisé a perdu un peu intérêt de son apparence extérieure, insister pour qu'il se garde propre encourager même la coquetterie chez les femmes. A la table la même chose, il n'est pas rare qu'un malade saisisse sa viande avec ses doigts sans se soucier de l'étiquette. Au moment opportun lui enseigner l'usage des ustensiles. A ce sujet une malade, que sa mère recevait en congé pour une fin de semaine pour la première fois après son opération avait, au désarroi de sa famille, manifestée une mauvaise tenue au repas. En la ramenant à l'hôpital sa mère, devant la religieuse, lui en fit une remarque assez cassante. Ce reproche fut très mal reçu de la part de la malade qui la semaine suivante appréhendait sa sortie. Une parole dite à propos, sans exagérer la portée d'une chose si peu grave en soi, aurait donné, j'en suis sûre, de bien meilleurs résultats. C'est pourquoi l'interprétation auprès de la famille et leur coopération intelligente a tant de valeur.

Le premier mois est très important et démontre souvent les résultats à attendre, les espoirs permis. Généralement le progrès continue un an et même davantage. Le succès attendu est souvent dépassé par un redoublement d'efforts, d'habileté, et de persistance.

Il serait recommandé qu'après cette période les malades soient classifiés en trois groupes — les retardés, les intermédiaires, et les avancés, ayant chacun un programme tracé d'heure en heure en raison de leurs capacités. Il serait à propos de les suivre toute la journée. Il est entendu que l'infirmière seule ne peut en quelque sorte déployer une attention individuelle pour chacun mais la coopération des

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Conférence donnée par Mlle Fernande Riverin, I.L., spécialisée en psychiatrie, à l'hôpital St. Jean de Dieu, Montréal.

aides et des infirmiers dans ce programme est très utile et permet de mener à bonne fin une oeuvre soumis à tant de rouages.

Comme je le disais plus haut les malades feraient leur toilette, s'occuperaient de leur lit et de leurs effets personnels. Dans l'avant-midi on les dirigerait vers l'occupation thérapeutique si un endroit à cet effet serait en opération. L'idée de sortir les malades de leur salle pour les travaux manuels ou autres a ça de bon, que l'atmosphère étant changé, ils y gagnent un nouvel intérêt. A l'hôpital à Ste. Anne de Bellevue, Qué., où un tel service existe, on peut voir à l'oeuvre les techniciens spécialisés enseigner aux malades les travaux les plus divers. Ailleurs où de tels départements ne sont pas inaugurés on voit cependant les groupes suivis, observés et encouragés à exécuter tout ce que l'ingéniosité peut suggérer. Les femmes apprennent la couture, le tissage, le tricot, la fabrication de tapis, divers objets en plastique, et des fleurs. Les hommes produisent des objets de toutes espèces. L'importance ce n'est pas l'intensité du travail mais l'intérêt, la persévérance, et le progrès du malade.

On observe que certains malades vont passer d'une tâche à une autre ou bien s'ils entreprennent un travail vont garder un oeil intéressé sur celui du voisin. Saisir l'opportunité et si cet intérêt est véritable confier à ce malade la tâche qui semble le tenter. Ne pas permettre que les malades commencent un travail sans jamais le finir. Cela arrive très fréquemment au début surtout. La garde-malade doit encourager fortement le malade à réaliser qu'une tâche accomplie apporte une grande satisfaction. Il faut aussi tenir compte de ses capacités, de son éducation, de ses goûts, de son métier, et de ses talents.

Il se trouve des malades ayant de réelles aptitudes pour les arts, les encourager au besoin leur fournir des maîtres qui dirigeront ces aptitudes. Il serait intéressant qu'un programme scolaire soit inclus aux activités de la journée. Dans une organisation à son début, c'est peut-être téméraire de suggérer un tel item mais il a été prouvé qu'une ou deux heures de classe par jour permettait aux malades de récupérer leurs connaissances déjà apprises et oubliées. D'autres malades montreront des dispositions pour de nouvelles matières, les acheminant peut-être dans une sphère pratique où l'issu serait un emploi dans la vie sociale.

Pour joindre l'utile à l'agréable, organiser des promenades, piqueniques, et des séances de gymnastique en plein air. A ce sujet ne pas oublier de couvrir la tête des femmes tant que les cheveux ne sont pas repoussés, pour le garantir du froid et du soleil et aussi pour éviter les remarques désobligeantes de la part d'autres malades devant leur tête rasée. Ne pas oublier une sieste après dîner et aussi une collation qui est chez tous bienvenue. Durant la soirée en organisera des soirées où les malades de différentes salles se grouperont, facilitant ainsi le contact avec le milieu environnant et conduisant graduellement le malade vers une résocialisation plus complète.

Ce programme brièvement élaboré donne un faible aperçu de ce que devrait être la routine des malades lobotomisés dans un service spécialisé. L'exposé semble assez facile mais celles qui en ont l'expérience savent que les choses ne vont pas sans difficulté. Il faut s'armer de patience illimitée et de bonté. L'infirmière responsable d'un tel service doit cultiver son sens d'observation afin d'utiliser le moindre critère pour l'intérêt du malade, posséder une personnalité dynamique et enthousiaste. Le champ d'action est immense et les résultats, qui ne sont peut-être pas spectaculaire, dans tous les cas ont cependant donné de bien grandes consolations.

Combien de malades, destinés pour la vie à occuper une place à l'asile, vivant béatement à se balancer sur un banc, ayant complètement rompu avec le monde extérieur, se voit maintenant changer d'un être incompréhensif en un individu plus sociable et aux manières plus naturelles. Et combien d'autres, ceux-là

en plus d'être inutiles, étaient dangereux pour eux-mêmes et pour les autres, vivant des années peut-être dans une cellule, souvent en plus, sous contrainte, occupant un personnel nombreux, devenir après l'opération et le traitement de réhabilitation des êtres calmes, rendant de menus services à l'hôpital, faisant la vie communautaire moins morne; et pour ceux qui n'auront pas été touché la science a d'autres perspectives—la topectomie et la thalamomectomie.

Il est un peu tôt pour donner des résultats définitifs sur cette technique, la lobotomie étant une thérapeutique si jeune mais l'espérance la plus légitime est permise. Il n'est pas possible de donner des statistiques, d'ailleurs on sait ce qu'elles valent. Déjà à St. Jean de Dieu sur 35 malades opérés, il y eut 6 congés, 4 autres aptes à retourner dans leur foyer. Si on considère que la lobotomie est pratiquée depuis février, 1948, soit un mois et que 25 autres ont tous pour la plupart subi une amélioration notable et utile. A Ste. Anne de Bellevue en deux ans 23 malades ont été opérés, deux sont en congé, continuant une réhabilitation assez remarquable. Le reste de patients sauf deux ont certainement profiter de l'intervention en ce sens qu'ils se sont réadaptés à la routine de l'hôpital, donnant espoir de nouveau progrès.

Certains auteurs suggèrent pour les lobotomisés, dont l'amélioration serait retardée ou arrêtée présentant une phase d'agitation avec impulsivité, bénéficieraient de l'intervention de quelques électro-choc ou une cure d'insuline avec d'assez bons résultats.

Le lobotomisé dans son ascendance vers la résocialisation et non la guérison aura acquis une personnalité absolument typique; certains auteurs l'ont décrit et l'observation le confirme. Un malade arrivé à un stade de récupération sera malgré tout un être diminué.

On note de Ch. Brisset une description de la personnalité du lobotomisé:

1. Modifications du *status émotionnel:* Le malade semble dépourvu d'émotions pour ce qui concerne la prévision, les préoccupations du futur; d'où la perte des ambitions, l'indifférence à l'opinion, le retour à un stade de moindre maturité émotionnelle.
2. Modifications de *l'activité et du status intellectuel:* Toutes les acquisitions intellectuelles demeurent intactes; un entraînement quelconque même à des exercices abstraits n'est pas altéré par l'opération. Mais la mise en train est lente, difficile, non spontanée. Elle consiste en une perte ou diminution de l'activité créatrice.
3. Modifications du *comportement social:* La lobotomie altère le pouvoir d'estimation éthique; d'où une conduite déterminée par les facteurs objectifs de l'environnement libérés des éléments personnels de responsabilité. Cela permet dans des meilleurs cas une adaptation sociale réussie; en plus, manque d'imagination constructive et d'un défaut profond d'estimation des responsabilités personnelles.

Quand le programme de réhabilitation a donné de bons résultats et que le malade est retourné dans son foyer, il sera sage de revoir ces malades dans les cliniques psychiatriques afin de leur accorder une surveillance médicale, les diriger dans leur nouvelle voie existentielle par des entrevues régulières. Dans le cas de l'apparition d'un symptôme nouveau ou d'un comportement anormal, le psychiatre verrait à appliquer la technique thérapeutique adéquate, évitant une rechute ou un nouvel accès.

La famille serait bien éclairée sur l'attitude du malade—ce à quoi elle peut s'attendre, comment se comporter, etc. Le service social pourrait faire le lien entre l'employeur et le lobotomisé dans l'orientation d'un emploi. Il faudra que ce travail soit proportionné à ses forces, ses capacités, et sa résistance. C'en un gage de succès quand, dans un cadre normal, un individu gagne sa subsistance.

Tout malade, ayant subi une intervention cérébrale ou un traumatisme crânien, doit éviter l'usage de l'alcool; c'est particulièrement sérieux chez les lobotomisés qui risquent fort en passant outre de gâcher un travail long et précieux et abolir les meilleurs résultats.

Nous avons confiance que ce programme, dont l'intervention chirurgicale n'est que le pas initial, reste dans les découvertes modernes un des plus fécond traitement de la psychiatrie. Il permet à l'infirmière devouée, qui ne craint pas une tâche lourde et ardue, de collaborer d'une façon magnifique à l'édification nouvelle d'êtres qui hier encore étaient voués à la plus lamentable déchéance, n'ayant d'autres perspectives qu'une vie inutile et lamentable dans un asile d'aliéné.

In Memoriam

Barbara Balfour, who graduated from St. Paul's Hospital, Vancouver, in 1912, died on November 14, 1950, after a long illness.

* * *

Minnie DeHertel Brown, who graduated from the Freemasons' Hospital, Morden, Man., in 1900, died in Winnipeg on October 21, 1950. For a time Miss Brown was senior nurse at the Ninette Sanatorium. She retired from active work 13 years ago.

* * *

Georgina Comartin, a graduate of St. Boniface Hospital, Man., died in Toronto on November 9, 1950. Miss Comartin saw active service during World War I.

* * *

Nellie Gill Dunnington, who graduated with the second class of the Toronto Western Hospital, died in Toronto on November 28, 1950, in her 83rd year. Miss Dunnington had engaged in private nursing until her retirement eight years ago.

* * *

Ruth Dunoon, of Owen Sound, Ont., lost her life in an aircraft accident the latter part of October, 1950.

* * *

Evelyn S. Elliott, a graduate of the Montreal General Hospital, died in Montreal on November 29, 1950, at the age of 47. Before enlisting with the R.C.A.M.C., Miss Elliott was engaged in child welfare work in Montreal. Going overseas in 1941, she served in England and in Italy with No. 14 C.G.H. She had been on the staff of Queen Mary Veterans' Hospital, Montreal, since her return to Canada.

* * *

Verna (Martin) Geddes, who graduated from the Regina General Hospital in 1944, died suddenly on August 21, 1950, at the age of 28.

Ella (Gendron) Hayes, a graduate of Harper Hospital, Detroit, who gave generously of her skills and services in Meyronne, Sask., where the nearest doctor was 50 miles away, died there on December 4, 1950.

* * *

Muriel Maxine Hazelwood, who graduated from the Providence Hospital, Moose Jaw, Sask., in 1949, died in Nelson, B.C., in November, 1950, at the age of 28. Prior to her training, Miss Hazelwood had served with the Women's Division of the R.C.A.F. during World War II.

* * *

Lula (Sunderland) Kingsbury, a graduate of the Ontario Hospital, Brockville, died on October 28, 1950, at the age of 57, as the result of severe third-degree burns.

* * *

Frances Sophia MacMillan, a graduate of the Royal Victoria Hospital, Montreal, died in Victoria on November 24, 1950, at the age of 74. During her years in active nursing Miss MacMillan had served as superintendent of nurses at the Calgary General Hospital, Royal Alexandra Hospital, Edmonton, and the Methodist Episcopal Hospital, Indianapolis.

* * *

Etta McLeay, a graduate of the Hamilton General Hospital in 1906, died in Toronto in November, 1950, at the age of 68. Miss McLeay had operated Chatham House Hospital in Vancouver for many years prior to her retirement last spring.

* * *

Annie Mabel McLeod, who graduated from Carleton County (Ont.) Protestant General Hospital in 1911, died at High River, Alta., on November 13, 1950, at the age of 66, following a lengthy illness. Miss McLeod served as matron of the High River Hospital,

1915-28. She went to Vulcan Hospital for eight years. In 1940 she took over the matron's duties at the Oilfields Hospital in Turner Valley.

* * *

Mary Elizabeth Robinson, a native of Saint John, N.B., died recently in Plainfield, N.J. Miss Robinson went to the United States to train and all her professional life was spent there. She graduated from Long Island College Hospital. During World War I she was affiliated with the Jane A. Delano American Legion Post. She was director of nurses at L.I.C.H. for 11 years, leaving there to accept the position of assistant superintendent of Muhlenburg Hospital in Plainfield. She held this position until her retirement.

* * *

Frances Elizabeth Sharpe, who graduated from the Toronto General Hospital in 1897, died in Toronto on November 7, 1950. In 1898 Miss Sharpe became the superintendent of nurses of the Woodstock (Ont.) General Hospital. She had retired from that position about 20 years ago.

* * *

Minnie (Clark) White, who graduated from the Toronto General Hospital in 1894, died on September 29, 1950.

* * *

Agnes R. Wilson died in Nelson, B.C., on October 25, 1950, at the age of 53.

U.S. Civil Defence Training for Professional Nurses

As part of its program of training for civil defence, the National Security Resources Board of the United States has completed arrangements for a series of courses of instruction for a limited number of selected professional nurses in the "Nursing Aspects of Atomic Warfare." The first course was conducted at Rochester, N.Y., by the Atomic Energy Commission. The other five are under the Public Health Service. Each of the states and territories and the District of Columbia has been requested to assist in the selection of nurses for attendance at the training courses and an invitation has been graciously extended to Canada to send a limited number of nurse representatives also.

The purpose of the course is to provide a nucleus of trained teacher-nurses in the field of atomic medicine. It is planned that those completing these courses will be available in state or provincial training programs to train other nurses to teach on the state or provincial level.

The cost of these courses of instruction has been assumed by the U.S. Government with other expenses borne by the state or participant. It is contemplated that the cost of subsequent training programs for nurses will be the responsibility of governments on the state or provincial level. Candidates for these training courses are nominated by the governor of the state or his appointed delegates. If the governor appoints a committee to assist him, it is suggested that such a committee include representatives from the State Nurses' Association, the State Department of Health, and each university.

Each course of instruction extends over a five-day period. The program has proceeded in the following regional centres on the dates indicated: Atlanta, Georgia—January 8-12; New Orleans, Louisiana—January 15-19; Minneapolis, Minnesota—January 29-February 2; Denver, Colorado—February 5-9; San Francisco, California—February 12-16.

Each candidate for this instruction should be:

(a) A fully qualified registered nurse, with adequate preparation in the natural sciences.
(b) A competent, experienced teacher or educator.
(c) In a position to teach nurses in state training programs and willing to undertake such instruction.
(d) Interested in the nursing problems of atomic warfare and in cooperating with state and community civil defence organizations.

The candidates nominated have, as far as possible, included representatives from each of the following:

(a) Universities or colleges offering advanced or basic courses in nursing.
(b) Outstanding hospital schools of nursing.
(c) The State Department of Public Health.

(d) The State Nurses' Association.
(e) American National Red Cross Nursing Services.

Because of the technical nature of the training, individual qualifications of candidates are reviewed by the federal agencies concerned with the training project. Upon acceptance, the National Security Resources Board issues invitations to the individuals selected for the training and furnishes them with the additional information they will need before enrolling in the courses.

At the Atlanta sessions, Canada was represented by Miss Helen McArthur, president, Canadian Nurses' Association; Miss Gertrude M. Hall, general secretary, C.N.A.; Miss Winonah Lindsay, Department of Veterans Affairs, Saint John, N.B.; and Miss Emily Groenewald, D.V.A., Ste. Anne de Bellevue, Que.

In Our Mail

Dear *Editor:*

I am not one who usually writes to the editor but an article recently carried by the newspapers roused me to action. In this commentary a comparison was made on the salaries of nurses and those paid to other occupational groups in Canada. The income tax analysis showed that the average salary paid to nurses across Canada amounted to $1,319 or very little more than $100 per month. This looks pretty bad in cold print and, as we know that many nurses receive a much higher rate than the one quoted, it follows that in order to strike this average many must receive much less. What happens to these nurses when illness strikes? They may eke out an existence under normal conditions but under stress must depend upon family and community assistance. In one large eastern city, the municipal health department offers to stenographers with two years of high school and two years' experience a salary ranging from $1,400 to $2,100 per year.

One does not live by bread alone but one must have bread in order to live. Why should parents give their daughter four to five years of high school education and support her for another three years in a nursing school if at the end of this period she cannot earn an annual living wage sufficient to entitle her to a suitable standard of living and the opportunity to save against the lean years? As one nurse put it recently, "Hospitals can find the money to meet every other expense, but when it comes to nurses' salaries boards become very much upset over the cost to the patient!" All nurses appreciate the high cost of illness but they cannot help questioning why the nurse alone should be expected, through her lower income, to assume such a large proportion of the bills for illness in the community. This nurse continued: "Such a low value has been put upon the nurse's work that she has come herself to accept this low evaluation and to feel apologetic for even attempting to secure for herself what is a just evaluation of her services."

If the community, through their hospitals, want and need nursing service, is it not just and fair that they should find a way of remunerating adequately those who render the service?

I hope you will give this letter space in your interesting *Journal* because I think nurses should begin to bring their problems out into the open and discuss them from all angles.—"R. N."

* * *

Dear *Editor:*

May I add a word as to the enjoyment I receive from the *Journal?* I particularly enjoy the issues that treat of one medical or surgical condition from all angles. I have also been encouraged to add to my reference library from the book reviews provided.—E. F. W.

* * *

Dear *Editor:*

I just want to say how well I felt the biennial convention of the C.N.A. was reported in *The Canadian Nurse.* Even the material about the convention in the early part of the year was very informative, helpful, and well presented. It answered all the questions and must have saved provincial and national offices many inquiries.—V. L. G.

Ironing is frequently blamed for backache of which many women complain. The fault most frequently lies with the height of the board, especially when a tall person is using a board of standard height. This can be remedied by raising the level of the board by anchoring square blocks under the legs. Try sitting down while ironing.

Trends in Nursing

Visit to United States

THE GENERAL SECRETARY of the Canadian Nurses' Association, Miss Gertrude Hall, was one of the speakers at the 36th annual Clinical Congress of the American College of Surgeons (Hospital Section Meeting) held in Boston, October 23-27, 1950. Her topic was "The Present Status of Nursing Throughout Canada." Miss Hall embodied in her paper certain particulars regarding the demonstration school at Windsor and the more recent development in nursing education now being carried out at the Toronto Western School for Nurses. Great interest in these experimental programs was displayed by the American nurses and hospital administrators.

National Secretaries in Ottawa

Miss G. M. Hall and Miss Marion Nash were present at a general meeting of District 8, Registered Nurses' Association of Ontario, held at the Chateau Laurier, November 24, 1950.

Instead of addressing the meeting, Miss Hall arranged for an informal exposition of the work of National Office through a discussion dealing with various aspects presented by the morning's mail.

Factors leading up to the structure study were outlined. It was explained that when the study was proposed the present objectives of the association were reviewed and a re-examination of these objectives was found to be indicated for the following reasons:

(a) A changing concept of nursing itself; (b) the demand for nursing services and the relation of governmental authorities to that demand; (c) a developing sociological emphasis in all fields of medicine, with its significance for nursing; (d) change in concept of nursing education; (e) responsibilities of the national association for more adequate interpretation of nursing to nurses themselves and to the public who are consumers of nursing service.

In response to a question, the following was presented as a likely pattern for the study to follow:

(a) A re-examination of the purposes of a national professional organization and of the functions necessary to achieve these purposes; present objectives; (b) a study of the inter-relationships of the national and the provincial nurses' associations; (c) a consideration of the relation of the purposes and functions of the C.N.A. to (i) the nurse, (ii) society, including the relationship of the C.N.A. to organizations working in the field of health and welfare—official and unofficial; (d) a survey of existing machinery and personnel, with a view to a more adequate fulfilment of these purposes, functions, and relationships.

The need for an educational secretary, her qualifications and proposed functions, the Nursing Care Study and methods of solving the problem of nurse shortage were all discussed as part of the long-range program of the C.N.A. for the present biennium.

What Others are Doing

National Office secretaries represented the C.N.A. at the meeting of the Joint Planning Commission, Canadian Association for Adult Education, held in Montreal, November 24, 1950. Considerable time was given to the reports of the various organizations, the materials they were preparing, and their plans for the future. Over and over again, the importance of adult education was stressed and methods of disseminating information by means of press, radio, forum, etc., enlarged upon. The need for everyone to be informed on what U.N., WHO, and UNESCO are doing, methods of securing U.N. materials, and the worthwhileness and readability of the materials being published were discussed. The Canadian Citizenship Council reported on a joint venture with the Canadian Foundation, publication of a cultural series, revision of government teaching aides, four

new pamphlets on the democratic way of life, a free monthly bulletin, etc., and that a national conference on Canadian Citizenship was to be held this spring.

U.N. Headquarters, Montreal, mentioned that material might he had on loan from their headquarters and commented on the series of pamphlets "World Review for Canadian Schools" and the good response from the schools. The Chamber of Commerce explained their interest in educational research as part of a program to interest business men in education and to promote good relationships between business and those who teach. The Canadian Citizenship Branch of Quebec reported publication of 30 brochures on the ethnic groups making up our population. The Department of Labor mentioned the documentary film "Date of Birth" and the excellent response of employers to the showing of this film.

Workshops in British Columbia

British Columbia is to the fore in conducting workshops in group discussion. Several have been held in Vancouver, a few in other centres. In these workshops, members spend part of the time in general sessions and then divide into small groups of eight or ten for "practice" discussions. To make this experience more meaningful, members analyze each practice session. In these analyses, the emphasis is on the inter-relationships in the group and the resulting influence on discussion. This process helps to develop insight and understanding of people's needs, motives, and behavior which are considered very important to effective group participation. This concept of group discussion is considerably different from that sometimes assumed. Instead of coaching chairmen in the technique of "handling" people in their groups, the attempt is made to help both chairmen and members to develop insight into human relations and to accept responsibility not only for making their own participation effective but also for facilitating the "growth" of others, based upon their understanding of the group process.—*Canada's Health & Welfare*, Oct. 1950.

Human Rights

The Trades and Labor Congress, in their report on discrimination to the 64th convention at Calgary, recommended as an interim measure "that a Declaration of Human Rights be adopted by the Parliament of Canada." Such a declaration would state that everyone in Canada has duties to the community and is subject to such limitations as are determined by law, for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order, and of the general welfare and good government of Canada.—*Labour Gazette*, Nov. 1950.

Canadian Bill of Rights

Saskatchewan's request that the Bill of Rights be written into the Canadian Constitution will be reiterated when the Dominion-Provincial Conference reconvenes in December. Saskatchewan's stand from the beginning of the Conference has been that a Bill of Rights, guaranteeing the fundamental freedoms and the rights of the individual, is overdue. This province, as early as 1944, passed a Bill of Rights guaranteeing to every citizen the right to freedom of conscience, opinion and belief; the right to freedom of religion and worship; the right to freedom of expression including the press, radio, and the Arts; the right to freedom of assembly; the right to freedom from arbitrary arrest or detention and the right to demand an election every five years.—*Saskatchewan News*, Nov. 15, 1950.

Youth Training

Student Aid consists of financial aid in the form of a loan, outright grant, or combination of both, given at the discretion of each province to

students to make possible continuation of their courses. Apart from Quebec and the four western provinces, at whose request a special section of the schedule provided for assistance to nurses-in-training at hospitals, the plan was restricted to university students registered in a course leading to a degree.—*Labour Gazette*, Nov. 1950.

Orientation et Tendances en Nursing

En Visite aux Etats-Unis

La secrétaire générale de l'Association des Infirmières du Canada, Mlle Gertrude M. Hall, fut une des conférenciers au 36e congrès annuel de l'American College of Surgeons (section des hôpitaux) tenu à Boston du 23 au 27 octobre 1950. Elle parla du statut de l'infirmière à travers le Canada. Mlle Hall fit entrer dans son sujet certains détails concernant la démonstration faite à l'école de Windsor et les développements plus récents, dans l'éducation de l'infirmière, apportés par l'école d'infirmières de l'Hôpital Toronto Western. Les infirmières américaines et les administrateurs d'hôpitaux montrèrent un grand intérêt.

A Ottawa

La secrétaire générale et son assistante, Mlle M. Nash, assistèrent à l'assemblée générale du District 8 de l'Association des Infirmières Enregistrées de l'Ontario, tenue au Château Laurier, le 24 novembre 1950.

Au lieu d'adresser la parole à l'auditoire, Mlle Hall prépara une exposition du travail fait au Secrétariat National. Le courrier du matin, l'étude, et la solution des problèmes présentés étaient le thème de cette exposition.

Les facteurs ayant déterminé l'étude de l'organisation de l'A.I.C. furent présentés. Lorsque cette étude fut proposée, les buts, la fin de l'A.I.C. furent revisés et une nouvelle étude de ces buts sembla nécessaire à cause

des facteurs suivants: (a) Le caractère de la pratique du nursing n'est plus le même qu'autrefois; (b) la demande des services de l'infirmière et l'attitude des gouvernements concernant cette demande; (c) le développement marqué de l'aspect social de la médecine et l'influence de ce développement sur le nursing; (d) changements dans l'éducation de l'infirmière; (e) responsabilités pour l'association nationale d'une interprétation plus adéquate du nursing à ses membres et au public, employeur éventuel des infirmières.

En réponse à une question, le plan suivant fut donné comme pouvant servir de base à l'étude projetée: (a) nouvel examen des buts d'une organisation professionnelle nationale et les moyens d'atteindre ces buts; (b) une étude des relations entre les associations provinciales et l'association nationale; (c) considérer les relations, les buts, et la fonction de l'association nationale envers (i) l'infirmière, (ii) la société, incluant les organisations intéressées à la santé et au bien-être; (d) une étude du personnel, attributions, etc., dans le but d'atteindre les buts proposés.

A cette assemblée l'on discuta également des besoins d'une secrétaire spécialement chargée de l'éducation, les qualifications requises et les attributions de cette secrétaire; une étude sur les soins aux malades et les méthodes à adopter pour résoudre le problème de la pénurie d'infirmières. Voilà le travail sur la planche que des mains laborieuses auront à accomplir d'ici le prochain congrès biennal.

Que Font les Autres?

L'Association canadienne de l'Education des Adultes (commission des projets) eut une réunion à Montréal, le 24 novembre 1950. L'importance qu'il y a pour chacun d'être renseigné sur les activités des Nations Unies, de l'Organisation Mondiale de la Santé, et de l'UNESCO fut de nouveau mise en évidence. Parmi les groupes représentés à cette réunion il y avait le Conseil canadien des Citoyens, la Chambre de Commerce, et l'A.I.C. par les secrétaires. Chacun des groupes rapporta les publications mises à la portée du public pour le renseigner.

Entre autre nous signalons, de la part du Conseil canadien des Citoyens et le Canadian Foundation, une revision des publications du gouvernement, feuillets, etc. Le Conseil, section du Québec, a publié trente brochures sur les groupes ethniques formant notre population. Le Ministère du Travail a mentionné le film documentaire "Date de Naissance" qui a été accepté avec enthousiasme.

Cercle d'Etude en Colombie-Britannique

Afin de bien apprendre à discuter et comment diriger les membres de leur petits groupes, plusieurs cercles d'études furent organisés à Vancouver. Les résultats se font déjà sentir, meilleure compréhension à la fois des problèmes des unes et des autres et des personnes. — *Canada's Health & Welfare*, oct. 1950.

Droits de l'Homme

La Gazette du Travail de novembre 1950 rapporte que les unions et les syndicats ouvriers lors de leur 64e congrès recommandèrent au Gouvernement canadien "d'adopter une déclaration des droits de l'homme." Cette déclaration devrait contenir que chaque citoyen canadien a des devoirs envers la société; qu'il doit observer les lois, afin d'assurer au prochain la liberté de ses droits, une bonne morale et l'ordre public, le bien-être et un bon gouvernement au pays.

Une Loi Nationale des Droits de l'Homme

La Saskatchewan demande qu'une loi, reconnaissant les droits de l'homme, soit inscrite dans la Constitution du Canada. Dès l'ouverture de la conférence inter-provinciale, la Saskatchewan a été en faveur de l'adoption d'une loi, garantissant à tout individu la liberté de ses droits. Dès 1944, une loi fut adoptée en Saskatchewan, garantissant à tout citoyen la liberté de conscience, d'opinion, et de croyance; le droit de pratiquer librement sa religion; la liberté d'opinion de la presse, de la radio et des arts; le droit de se réunir en assemblée; le droit à la liberté lors d'un arrêt ou d'un emprisonnement arbitraire et le droit de demander une élection tous les cinq ans.—*Saskatchewan News*, 15 nov. 1950.

L'Aide à la Jeunesse

L'aide aux étudiants consiste en une aide financière sous forme de prêt ou d'octroi ou les deux réunis, donnée à la discrétion de chaque province afin de permettre à des élèves de continuer leurs études. Sauf dans Québec et dans les quatre provinces de l'ouest où, à cause de demandes spéciales, une certaine somme est mise à la disposition d'étudiantes infirmières, cette aide n'est offerte qu'aux étudiants inscrits à une université, à des cours conduisant à un degré universitaire.—*La Gazette du Travail*, nov. 1950.

Several Canadians attended the Workshop on Financial Administration in Schools of Nursing, sponsored by the Conference of Catholic Schools of Nursing, held at Chicago, Ill., December 4-7, 1950. Shown in the photo from left to right are: MR. GORDON PICKERING, *comptroller, St. Boniface Hospital, Man.;* SR. DENISE LEFEBVRE, S.G.M., *director, Institut Marguerite d'Youville, University of Montreal;* LOLA WILSON, *registrar, Saskatchewan Registered Nurses' Association;* SR. M. BERTHE DORAIS, S.G.M., *superior and administrator,* St. Boniface Hospital.

Also present from Canada were: SR. M. ROSE LACROIX, S.G.M., *instructor, Institut Marguerite d'Youville;* SR. DELIA CLERMONT, S.G.M., *director of nursing, St. Boniface Hospital;* SR. A. STE. CROIX, S.G.M., *director of nursing, St. Paul's Hospital, Saskatoon, Sask.* and SR. A. LEVASSEUR, S.G.M., *educational director, Grey Nuns' Hospital, Regina, Sask.*

Hair

If you have ever said that "hair comes out by the roots," don't say it again because hair does not have any roots. The end of a hair shaft is like a tiny bulb which fits over the papilla—the source of blood and nourishment for the hair. When a strand of hair "falls out" the bulb is pulled off the papilla. Unless the latter is damaged in some way a new strand of hair will grow in place of the old.

A single strand of hair, examined under a microscope, is both interesting and surprising. There are three layers. The first, the cuticle, consists of five transparent cells, overlapping as do the shingles on a roof. The second layer, the cortex, contains the coloring matter which shows through the transparent cells. Freshly washed hair looks brighter as the color can shine through. This layer is dotted with tiny openings which hold the oil. Through the innermost section, the medulla, nourishment is carried to the whole strand.

—*Canadian Pharmaceutical Journal*

Vitamin C was unknown 35 years ago and the routine feeding of orange juice to babies is a development of the last quarter century.

Book Reviews

Guiding Learning Experience—Principles of Progressive Education Applied to Nursing Education, by Maude B. Muse, R.N., A.M. 617 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1950. Price $4.50.

Reviewed by Helen E. Penhale, Professor of Nursing, University of Alberta.

This book deserves careful consideration by instructors of nurses. It "offers an understanding of the terminology and theories of the science and art of education heretofore unavailable to the nurse educator in daily practice. More than just a review of older principles, methods, and applications, it is an exposure to newer concepts and philosophies as well."

Drawing upon a fund of personal knowledge, acquired in both nursing and teaching, the author presents a vast amount of material in a well organized manner. Unit One deals with a frame of reference in nursing education. It is technical and is not easy reading. It

provides much thought-provoking material and will be of advantage to instructors who desire a more complete understanding of present-day philosophies of education.

The second unit covers educational principles. The application of the principles to actual teaching-learning situations in nursing enhances the value of this section of the book.

Teaching methods appropriate in progressive education is presented in Unit Three. The chapter on evaluation is particularly good. The so-called traditional methods of teaching, methods of clinical instruction, and the less frequently used methods such as symposium and workshop are included.

The concluding unit deals with organization of teaching-learning units.

There are carefully selected references and suggested learner activities at the end of each unit and chapter.

The volume has a rather limited use in schools of nursing. Much of the material is abstract and leaves the reader confused. It lacks the necessary simplicity to help the inexperienced instructor with any one particular phase of teaching. The terminology used is completely foreign to the average instructor. Students at the post-graduate level would find the book of value as a reference.

Maternity Care in Two Counties—Gibson County, Tenn., and Pike County, Miss., 1940-41, 1943-44, by Frank W. Whitacre, M.D. and Ellen Whiteman Jones, M.P.H. 165 pages. Published by The Commonwealth Fund, 41 East 57th St., New York City 22. 1950. Price (in U.S.A.) 50 cents. *Reviewed by Barbara R. Tunis of Fredericton.*

In 1937-38 "Delivery Nursing Services" were inaugurated as part of the public health program of two counties in the southern United States. This little volume is an evaluation of these services, based on health department records and a review of cases with physicians. The study was made possible through The Commonwealth Fund and concerns the years 1940, -41, -43, -44.

Two broad questions are kept in mind: "Did these services achieve the objects for which they were originally designed?" and "Would such services meet the present-day needs of rural communities?" As a result of the study, certain improvements in the maternity program become obvious—e.g., the number of patients with prenatal and postnatal nursing supervision increased about 20 per cent; standards of obstetric technique at delivery were raised. At the same time maternal and infant mortality rates decreased—perhaps the most conclusive evidence of the effect of the service.

Findings are reported in detail and emphasis is placed on the preventive aspects of maternity care: necessity for careful weighing of patients and reading of blood pressure to detect early toxemia; the importance of chest x-ray and blood test early in pregnancy; the

value of nursing care during the third stage of labor; the value of the six-week postpartum examination, etc. Administrative details of the program are likewise discussed.

Although the areas in which the study was made differ from comparable Canadian areas in many respects—economic, ethnic, geographic, cultural—and although some of the findings may not be applicable to the Canadian situation, yet all those interested in a public health maternity program will find much of value in this study. It will be of especial interest in those areas contemplating a delivery nursing service, while organizations already carrying this type of service will find much useful material here.

Bacteriology and Pathology for Nurses, by E. Irene Clark, M.B., B.S. (Lond.) 320 pages. Published by Faber & Faber Ltd., London, Eng. Canadian agents: British Book Service (Canada) Ltd., 263 Adelaide St. W., Toronto 1. 2nd Ed. 1949. Illustrated. Price $3.75.

Reviewed by Margaret Lonergan, Science Instructor, St. Paul's School of Nursing, Vancouver.

Miss Clark has written her book "to give the nurse such facts as she needs for examination purposes and, in addition, a little understanding of the subject, together with some practical details which may prove useful." The book is divided into three parts. The first deals with a history of bacteriology and pathology, a description of bacteria—their activities and relation to man. The second is devoted to the blood and its composition in health and disease. It includes types of blood tests, their meaning and relative value. The third is a section describing the microscope and its parts and more advanced material dealing with methods of examining laboratory specimens.

This is a valuable and practical book for the nurse who needs or wishes to understand the value of laboratory tests and examinations in the diagnosis and treatment of disease. The text gives a clearer and broader understanding of the causes of disease, the conditions that result, and the important part played by the laboratory in the field of medicine and research. It is an excellent reference book for even the newest student. For more advanced work, the presentation of the section on classification in Part III will be found exceptionally clear and easy to understand.

The work correlates bacteriology with

pathology and should, therefore, be of value to the student who has started bacteriology but is interested in following through to a greater degree of practical detail than most standard elementary texts provide. Color plates of blood cells and bacteria will be of interest to the more advanced student. The set-up of the material, unfortunately, is not impressive. Perhaps it could have been improved by an outline preceding or concluding each chapter. The style is interesting and makes for easy reading. No bibliography is listed but credit is given to individuals and literary firms for aid in producing the work.

Ophthalmic Nursing, by P. Garland, S.R.N., S.C.M. 158 pages. Published by Faber & Faber Ltd., London, Eng. Canadian agents: British Book Service (Canada) Ltd., 263 Adelaide St. W., Toronto 1. 1950. Illustrated. Price $3.00.

Reviewed by Ferne Trout, Itinerant Instructor, Registered Nurses' Association of British Columbia.

The author has in this volume endeavored to give a detailed account of basic ophthalmic nursing. It is practical and thorough in relation to nursing care, nursing treatments, and especially the necessary precautions indicating that Miss Garland has had wide experience in this field.

The diagrams, plates, and illustrations are helpful—clarifying her descriptions by their content and simplicity.

Notes on theatre technique are also of value to nurses doing operating room work, being general enough to apply to any set-up and yet stressing concisely the important points relative to the delicateness of this type of surgery in comparison to other types. However, for more advanced study in ophthalmology, anatomy and physiology, and operative procedures this book tends to remain on a very elementary level. This, I feel, was the author's intention and, therefore, for teaching student nurses or beginning post-graduates this book would be of value in a teaching department.

Nursing Sisters' Association

During the past year the *Montreal Unit* welcomed many new members into its ranks. Six executive and four general meetings were held.

The annual Memorial and Re-dedication Day Service was held on May 7 at St.

George's Church when the address was given by the Venerable Archdeacon A. P. Gower-Rees. Commemoration Day services were held on May 24 at the Field of Honor, Pointe Claire. On June 24 a garden party took place at the D.V.A. hospital at Ste. Anne de Bellevue, when the members were guests of the matron, Nancy Kennedy-Reid. Doris V. Watson attended the biennial meeting of the N.S.A.C. held in Vancouver in June. The executive of the national association was elected from members of this Unit with Janet MacKay as president.

Madeline Taylor, local president, with C. I. Nixon as wreath bearer, represented the nurses of both World Wars when a wreath was placed at the Cenotaph on Remembrance Day. Mr. John Fisher, CBC's Roving Reporter and commentator, was guest speaker at the Armistice Dinner when 110 members were present. Special guests included Gertrude M. Hall, general secretary-treasurer, C.N.A., and Margaret E. Kerr, editor of *The Canadian Nurse*, who both spoke briefly. Guests at the head table included: Mmes S. Ramsey, P. Bisaillon, J. A. Toller, Misses J. MacKay, E. Honey, C. I. Nixon, I. Henderson, B. Herman, N. Kennedy-Reid, G. MacLellan, H. Hewton, M. Russell, M. J. Latour, and J. McWade. Mr. Fisher, widely travelled and keenly observant, talked about his usual topic of "Canada." He was thoroughly interesting with his observations on the life and customs of the Canadian people from Newfoundland to British Columbia. Miss Taylor was in the chair and Miss Honey thanked the speaker.

In May and October military whists were held, proving successful both socially and financially.

Regret is expressed at the passing of Col. Agnes Neill, Nursing Sister Evelyn S. Elliott, immediate past president, and Nursing Sister Elva R. Coon.

Canadian Red Cross Society

The following are recent staff changes in the Provincial Divisions of the Canadian Red Cross Society:

British Columbia — APPOINTMENTS: *Mabel C. Taylor* as matron and *Kathleen Boyle* and *Noreen M. Beamish* (Vancouver Gen. Hosp.) to Terrace; *L. Castley* and *Jacqueline Hushin* to McBride; *Noreen Gobbo* and *Marney McLennan* (Vancouver Gen. Hosp.) to Lillooet.

Ontario—APPOINTMENTS: *Margaret Batte* (St. Joseph's Hosp., Hamilton) to Nipigon, *Marion Campbell* (Victoria Hosp., London, and B.Sc.N., University of Western Ont.) to Wilberforce; *Islay Bott* (Peterborough Civic Hosp.) and *Dorothy Thompson* (Gen. and Marine Hosp., Collingwood) to Bancroft; *Betty Dove* (Sarnia Gen. Hosp.) and *Bessie Still* (Soldiers' Memorial Hosp., Orillia) to Burk's Falls; *Ruth Lee* (Oshawa Gen. Hosp.) and *Beryl Lewis* (Hampstead Gen. and W.W., London, Eng.) to Emo; *Maxine Little* (Brantford Gen. Hosp.) to Atikokan; *Jean Morrison* (St. Michael's Hosp.) to Haliburton; *Janet Proudlock* (Toronto Gen. Hosp.) to Dryden; *Mary C. Stobie* to Richard's Landing. RESIGNATIONS: *Helen Farrow* and *Marjorie Sherk* from Wiarton; *Geraldine Garnett* from Port Loring; *Mrs. E. Johnston* from Burk's Falls; *Mrs. R. LaBarge* from Manitoulin Island; *Marion Latimer* from Dryden; *Thelma Lippert* from Matachewan.

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments—Montreal: *Mrs. N. Gleeson, Mrs. E. Moynihan* (University of Toronto), *Margaret Jones, Ruth Neeld* (Montreal Gen. Hosp.), and *Mrs. G. Hermann* (Royal Victoria Hosp., Montreal). Niagara Falls: *Mrs. E. McLeod* (Greater Niagara Gen. Hosp., Niagara Falls). Ottawa: *Mrs. E. Chatwin* (Vancouver Gen. Hosp.). Timmins, Ont.: *Mrs. M. Anderson* (St. Mary's Hosp., Timmins). Toronto: *Nori Arikado, Agnes Lacroix* (Metropolitan School of Nursing, Windsor, Ont.), *Anna Finlayson* (St. Michael's Hosp., Toronto), *Laura M. Ham, Mrs. M. Patterson* (U. of T.), *Eileen Kirton, Margaret Marshall* (McGill University), *Doris Matheson, Ruth Styles* (Toronto Western Hosp.), *Dorothy Lyle* (Toronto East Gen. Hosp.), *Josephine (Sweet) Schaljo* (University of Western Ont.), *Olga Shontoff* (Wellesley Hosp., Toronto), *Jeanne (Thomson) Sykes* (Kitchener-Waterloo Hosp.), and *Jean Tattrie* (Royal Victoria Hosp., Montreal). Vancouver: *Nancy MacDonald, Marion Russell* (Winnipeg Gen. Hosp.), *Fern Teed* (Toronto Gen. Hosp.), and *Mrs. E. Walcott* (University of Western Ont.). Victoria: *Elizabeth Freison* (Royal Jubilee Hosp., Victoria).

Re-admissions—Burnaby, B.C.: *Norma Kenney.* Hamilton: *Eileen (Soucie) Tomlinson.*

Montreal: *Mrs. E. Gonsalves.* Peterborough: *Lenore Mather.* Toronto: *Vera (Bruner) Gray.*

Transfers—*Bertha Klassen* from Windsor, Ont., to Sackville, N.B., as nurse in charge; *Heather Matthew* from Ottawa to Brampton, Ont., as nurse in charge; *Eileen Woodbyrne* from Timmins, Ont., to York Township, Ont.

Leave of Absence—Lincoln County: *Dorothy Nicol.*

Resignations—Brampton, Ont.: *Hilda Quick* as nurse in charge. Edmonton: *Peggy Milner.* Hamilton: *Mrs. P. Bartlett, Gwendolyn Marshall.* Lachine, Que: *Philomena Fuoco.* Moncton: *Frances Hall.* Montreal: *Mrs. A. Jollymore, Mrs. Norma R. Lee.* Niagara Falls: *Mrs. B. Gallinger.* North Bay: *Mary T. Murray.* Toronto: *Dorothy Buck, Mrs. N. Millson, Mrs. L. Pidd, Gurlie Robinson, Shirley Ross, Mrs. J. Taylor, Rosemary Vywyan, Doris Wareham.*

News Notes

BRITISH COLUMBIA

CHILLIWACK

In keeping with the holiday season, Chilliwack Chapter enjoyed a costume party at which comic-strip characters were well represented. Guests brought parcels of food and toys for the Community Chest. Charades, carols, and contests created considerable merriment, the program being arranged by Mrs. F. Barwell and her committee. I. Brown was in charge of the refreshments.

VANCOUVER

St. Paul's Hospital

In December the alumnae association entertained the students of the graduation class at a buffet supper when awards were presented to the best all-round students of each class. The students themselves selected the winners. The lucky girls were: Ruby Johnson (January, 1951); Helen Shellenberg (April, 1951); Ruth Nyhaug (September, 1951). Mr. J. Bullen, the first male nurse to graduate from St. Paul's, was also honored with an award.

Over $600 was realized on the bazaar when the nurses' home was filled to bursting with customers. The student nurses made $225 on their raffle and $67 on the sale of their dressed dolls. This money goes to the Student Council and is not included in alumnae returns. This is the first time the students and Sisters have participated in the bazaar and they did much towards its success. Ethel Black was the efficient convener.

June Clark was elected to represent T.C.A. at the International Air Show in California.

Thelma Lawton is taking a post-graduate course in obstetrics at the Chicago Lying-In Hospital. Mrs. Morgan is with the Metropolitan Health Fraser Unit after finishing her public health course at U.B.C. Paula Shworer is back to work at St. Paul's. Audrey (Tavender) Brandon is on the staff at Shaughnessy Hospital.

MANITOBA

BRANDON

At a meeting of the Association of Graduate Nurses reports were given on the C.N.A. convention held in Vancouver last June. Elizabeth Russell, director of public health nursing for Manitoba, introduced the guest speakers. Dorothy Dick, instructor of public health nursing, University of Manitoba, described her trip out to the coast and discussed the workshops and social activities which were part of the general meeting. Lillian Pettigrew, executive secretary, M.A.R.N., also spoke briefly of her observations at the convention.

M. Hettle thanked the speakers. Margaret Hart, director, School of Nursing Education, University of Manitoba, and Josephine DeBrincat, public health nursing supervisor, were special guests.

I. Lightly, who was appointed by the M.A.R.N. as delegate to the C.N.A. convention, was accompanied by E. Cranna and Mrs. G. Frizzell, all of the General Hospital staff. Miss Cranna has obtained an eight-month leave of absence in order to take a position as assistant clinical instructor at McMaster University School of Nursing, Hamilton.

ERICKSON

Vivian Smith, formerly of the Minnedosa district hospital staff, is now matron of the hospital unit here. She succeeds Mrs. A. T. Sloan. A native of Basswood, Man., Miss Smith is a graduate of the Dauphin General Hospital School of Nursing.

Winnipeg General Hospital

Members of the alumnae association held the annual candlelight carol service with the 1951 graduating class as special guests. Mrs. C. Dojack, president, was chairman. Mr. S. Osborne conducted the Glee Club and lead the gathering in carol singing. Dorothy Polson was guest soloist and S. Young pianist. The Christmas story from St. Luke was read by Helen Ross. The program convener was Mrs. Anderson.

NOVA SCOTIA

HALIFAX

The week of November 13 was an interesting and stimulating one for all who attended the refresher course on "The Teaching of Nursing," conducted by Jean Wilson, assistant professor, University of Toronto School of Nursing, and sponsored by the R.N.A.N.S. The sessions were held at the Victoria General Hospital and were well attended, the total registration of 103 nurses being representative

of all branches of nursing and of nearly every hospital in the province.

Miss Wilson developed (1) the meaning of nursing—to the patient, hospital administrator and staff, and to the student; (2) education, both general and professional, in the world of today; (3) teaching—principles and methods in the classroom and on the wards. By means of demonstrations, audiovisual aids, and planned conferences Miss Wilson brought out many points which otherwise might have been missed.

Also included in the program was an instructive lecture on cortisone and ACTH, given by Dr. J. F. L. Woodbury of the Department of Medical Research.

ONTARIO

District 4

Hamilton General Hospital

The annual meeting of the alumnae association was held in the out-patient department when routine discussion of business and the election of officers took place. Two members of the color photographic association outlined a few details of photography and showed color slides taken around Churchill, Muskoka, and Ottawa at different seasons.

Officers for the coming months include: Honorary president, C. Brewster; president, E. Ferguson; vice-presidents, G. Blyth, Mrs. E. Lamb; recording secretary and assistant, M. Cameron, R. Truscott; corresponding secretary, M. Irving; treasurer and assistant, D. Cosford, H. Cosford; secretary-treasurer and assistant, M.B.A., M. Morrow, A. Lush. Other officers include: E. Baird, C. Leleu, E. Bingeman, I. Mayall, M. Henderson, A. Welstead, D. Stock, M. Williams, M. Stewart, V. Pezzetta, J. Irwin, E. Weldon, K. Ingram, M. Watson, H. Alderson, J. Harrison, A. Scheifele, and Mrs. J. Bristow.

District 10

Fort William

Mrs. D. R. Easton presided at a meeting of District 10 when the minutes were read by H. Keith. Topics which came up for discussion included: Nurses' legislation; Red Cross first aid and disaster nursing; a brief on human rights and fundamental freedom pertaining to WHO. Mr. R. Porter, librarian at the Port Arthur Public Library, gave an interesting address on "Modern Libraries." The speaker was thanked by K. Feisel. Miss Howard, convener of bridge and canasta, reported that a cup and saucer had been awarded to B. Stock, Fort William Sanatorium, for the highest score.

McKellar Hospital

At a recent meeting of the alumnae association a presentation of a life membership was made to Jane Hogarth, a long-time member of the alumnae. The first life membership ever awarded in the organization, the presentation was made by Mrs. Des Higginbottom.

QUEBEC

MONTREAL

Herbert Reddy Memorial Hospital

Mrs. D. Rutherford presided at a recent meeting of the alumnae association when a committee of three was appointed to draw up a list of candidates for the forthcoming election of officers. Plans for entertainment for the future, guest speakers, etc., were also discussed.

McGill School for Graduate Nurses

Elva Honey, a graduate of the Winnipeg General Hospital, is acting director of the School. A nursing consultant with the Department of Veterans Affairs prior to taking up her present duties, Miss Honey was one of the first Canadian nurses to go overseas in World War II. Marion Lindeburgh, whose duties Miss Honey has assumed, has been granted a leave of absence because of ill health.

New district branches of the alumnae association have been formed, bringing the number up to six. They are located in Vancouver, Victoria, Saskatoon, Regina, Toronto, and Halifax. Several other groups are organizing at the present time and all are endeavoring to stimulate more outside interest in the School and to assist in obtaining contributions for the Endowment Fund.

Royal Victoria Hospital

A former graduate, Justine Delmotte, of Stellarton, N.S., is now public health nurse in Thailand with WHO. Miss Delmotte was a public health nurse in Montreal before receiving this new appointment.

SASKATCHEWAN

SASKATOON

St. Paul's Hospital

The annual Christmas Concert was held on December 21 and, as usual, delighted a large audience. Rev. Sr. A. Ste. Croix, director of nursing, attended a workshop on financial administration in schools of nursing held in Chicago. Lola Wilson, S.R.N.A. registrar, interviewed third-year students at the end of last year.

BERMUDA

The Christmas party, arranged by the King Edward VII Memorial Hospital Alumnae Association, was held at Montrose when gifts were brought for the children's ward and an overseas parcel. The Scholarship Fund is rising slowly. A Bring and Buy Sale and a tour of St. George's brought in about £12.

In December the alumnae association gave a party in honor of Melissa Smith, operating room supervisor at the hospital, who has retired after 40 years of faithful service. A gift of flat silver was presented to Miss Smith from graduates of the old Cottage Hospital and K.E.M.H.

Position Wanted

Advertising Rates—$5.00 for 3 lines or less; $1.00 for each additional line.

Registered Nurse, age 30, would like interesting position in country or suburbs where she can lead healthy outdoor life. Business course & experience as medical secretary & nurse in clinic & follow-up work. Apply c/o Box M, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Positions Vacant

Dietitian for 150-bed hospital. Salary depends on experience & qualifications. For particulars apply St. Joseph's Hospital, Chatham, Ont.

Registered Nurse for Ward Supervisor in Clearwater Lake Sanatorium near The Pas, Man. Background of training or experience in Tuberculosis Nursing preferred. Excellent accommodation, working conditions & salary. Pension plan. Group insurance. 4 wks. annual vacation plus 10 statutory & special holidays. Further detailed information will be supplied upon receipt of application, giving qualifications, experience & full personal particulars. Apply Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Man.

Industrial Nurse, preferably with experience in public health, surgical & out-patient clinic work. Duties cover clinical nursing & health counselling. Apply c/o Box 0, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Registered Nurse for General Duty in 25-bed General Hospital. Salary: $140 per mo. plus full maintenance. 44-hr. wk. Apply Supt., Louise Marshall Hospital, Mount Forest, Ont.

Registered General Duty Nurses for small hospital. Initial salary: $135 per mo. plus full maintenance & uniform laundry. Increase in 6 mos. 48-hr. wk. 4 wks. vacation. Liberal sick leave. Blue Cross available. Opening new hospital in April. Apply Supt., Niagara Cottage Hospital, Niagara-on-the-Lake, Ont.

General Duty Nurses for 39-bed hospital. 6-day wk. 3 wks. vacation with pay after 1 yr. service. 2 wks. sick leave per yr. Annual increase of $5.00 per mo. after 1 yr. Apply Supt., Arnprior & District Memorial Hospital, Arnprior, Ont.

Matron. Salary: $195 per mo. less $20 for maintenance. **General Duty Nurses (2).** Salary: $165 per mo. less $20 for maintenance. 17-bed hospital. Pleasant working conditions. Convenient to Calgary & Edmonton. Hospital Board will pay railway fare if period of employment is 6 mos. or over. 1 mo. leave with pay after 1 yr. service. Statutory holidays. 48-hr. wk. with no split shifts. Apply A. J. Schmiedl, Sec.-Treas., Municipal Hospital, Elnora, Alta.

Graduate Floor Duty Nurses for Mt. Hamilton Maternity Hospital, Hamilton, Ont. Large, well-equipped modern hospital (5,137 births in 1949) with opportunities for wide experience in Obstetrical Nursing. Vacancies on Delivery Floor, Nurseries, Postpartum Floors. 44-hr. wk. Statutory holidays. Bi-weekly salaries: $76-88. For other perquisites & further information write Supt.

Operating Room Nurse to be assistant to matron for 35-bed hospital. Salary starts at $195 with increments every 6 mos. 44-hr. wk. 1 mo. holiday with pay after 1 yr. service. Apply Mrs. C. Wilkinson, Matron, General Hospital, Ladysmith, B.C.

CANADIAN RED CROSS SOCIETY

invites applications for **Administrative** and **Staff** positions in **Hospital, Public Health Nursing Services,** and **Blood Transfusion Service** for various parts of Canada.

- The majority of opportunities are in **Outpost Services** in British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia.
- Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances.

For further particulars apply:

National Director, Nursing Services, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ontario.

CITY OF TORONTO

DEPARTMENT OF PUBLIC HEALTH

Qualified ***Public Health Nurses*** for a generalized public health nursing service. Salary $2,087 with yearly increases to $2,504 per annum, plus $4.00 weekly Cost of Living Bonus. Five-day week. Sick leave and pension plan benefits.

Apply **Personnel Department, Room 320, City Hall, Toronto.**

Graduates with Operating-Room experience for duty in modern, well-equipped Operating-Room Dept. Gross salary: $38-44 per wk. Opportunities for advancement to Staff positions for qualified graduates. Apply C. E. Brewster, Supt. of Nurses, General Hospital, Hamilton, Ont.

Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross salary: $38-44 per wk. 88-hr. fortnight. Hospitalization & medical benefits if ill. Apply C. E. Brewster, Supt. of Nurses.

Nursing Arts Instructor, Asst. Medical Supervisor & General Duty Nurses for 200-bed General Hospital. Salary: $195 & $175 plus Cost of Living Bonus respectively. 8-hr. day. 88-hr. fortnight. 4 wks. vacation annually plus statutory holidays. Sick time. Apply Supt. of Nurses, Royal Inland Hospital, Kamloops, B.C.

Graduate Dietitian at Ontario Hospitals in Kingston, Whitby. Initial salary: $2,140 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. at above hospitals.

Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock. Initial salary: $1,840 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. of Nurses at above hospitals.

Vancouver General Hospital requires: (1) **Pediatric Clinical Instructor**—Salary: $207-232; (2) **Clinical Instructor** (to include Gynecological Nursing)—Salary: $207-232; (3) **General Staff Nurses**—Salary: $177-207. Perquisites: 44-hr. wk; 11 statutory holidays; 28 days vacation; 1½ days per mo. cumulative sick leave; pension plan (if under age 35). Apply Director of Nursing, General Hospital, Vancouver, B.C.

Graduate General Duty Nurses for 50-bed General Hospital two blocks from sea & situated in delightful, renowned playground on Island Highway. Easy access to Vancouver & Victoria. Comfortable residence. References imperative. Basic salaries: $175 & $185 if one or more years' experience. Apply, stating age & experience, Lourdes Hospital, Campbell River, B.C.

Registered Nurses for General Duty in 200-bed hospital in Niagara Peninsula. 48-hr. wk., rotating shifts. Salary: $140 for day duty; $150 for evening duty; $145 for night duty, plus full maintenance & laundry. Increment of $5.00 per mo. at end of 1st, 2nd & 3rd yr. 21 days holiday at end of yr. & 9 statutory holidays. 1½ days sick leave per mo. accumulative to 18 days; staff re-imbursed if not used. Train fare refunded after 12 mos. service. Apply Director of Nursing, County General Hospital, Welland, Ont.

THE PROVINCE OF MANITOBA requires

NURSES

for the Hospital for Mental Diseases, Brandon, Manitoba.

Positions at various levels are vacant. Some positions require a certificate in Mental Nursing, others require that the applicant be a Registered Nurse.

Full Civil Service benefits—regular annual increases, liberal sick leave with pay, four weeks' vacation with pay annually, and pension plan.

Apply at once to:

MANITOBA CIVIL SERVICE COMMISSION
247 Legislative Building, Winnipeg, Manitoba

or

The Hospital for Mental Diseases, Brandon, Man.
Or to your nearest National Employment Service Office.

Registered Nurses for following positions with full maintenance in addition to salary: **General Duty Operating Room Nurse**—$130; **Head Nurse for Women's Floor** (34 beds)—$155; **General Duty Nurses**—$130 who alternate during day, afternoon & night shift; **Clinical Supervisor**—$160 per mo. Apply Supt. of Nurses, General Hospital, Medicine Hat, Alta.

General Duty Nurses—Medical, Surgical, Pediatrics, Maternity, Psychiatry, Tuberculosis. Beginning salary: $246. $10 differential Pediatrics, Psychiatry, Tuberculosis—evening & night shifts. 600-bed hospital with school. 40-hr. wk. 8 paid holidays. 3 wks. vacation. Laundry. Accumulative sick leave. Apply Director, Nursing Service, General Hospital, Fresno, California.

Registered Nurses for 56-bed hospital in Northern B.C. Basic salary: $185 less $44.25 for full maintenance in new residence. 1 mo. annual holiday & 10 statutory holidays. Railway fare either advanced or refunded after 6 mos. service. Apply, giving particulars of training & experience, Miss M. MacLeod, Supt. of Nurses, Wrinch Memorial Hospital, Hazelton, B.C.

Graduate Nurses for modern 100-bed hospital, 60 miles from Vancouver on Trans-Canada highway. Basic salary: $175 plus present C.O.L. adjustment $5 increase. 4 annual increments: $10, $5, $5, $5. Board, residence, laundry charges, $35 per mo. 44-hr. wk. 10 statutory holidays. 28 days annual vacation. 1½ days sick leave per mo. accumulative to 36 days. Apply Supt. of Nurses, Chilliwack Hospital, Chilliwack, B.C.

Graduate Nurses for General Duty (2). Gross salary: $180 per mo. **Laboratory Technician.** 35-bed hospital. White population. 4 wks. annual vacation. 10 statutory holidays. 44-hr. wk. Residence. Transportation up to $45. Annual increments. Apply Sister Superior, Providence Hospital, Fort St. John, B.C.

General Duty Nurses. Salary: $170 plus yearly increments. 8-hr. day, 44-hr. wk. Apply, giving age, Matron, Nanaimo Hospital, Nanaimo, B.C.

Nursing Arts Instructor (1) & Science Instructor (1). New hospital now under construction. For further information apply Supt., Charlotte County Hospital, St. Stephen, N.B.

Public Health Nurse (with car) to evaluate patients previous to admission (516-bed hospital for Extended Illness); to evaluate patients' needs on discharge; to take charge of Employee Health & relieve in Hospital Administration. Salary open, depending on qualifications. Modern living quarters if desired & garage. Apply Supt., Queen Elizabeth Hospital, 130 Dunn Ave., Toronto 3, Ont.

Public Health Trained Nurse (bilingual) immediately for The Bell Telephone Co. of Canada in Laurentian District; nurse's headquarters in Three Rivers. Write, stating qualifications & experience, Nursing Supervisor, Rm. 930, 1050 Beaver Hall Hill, Montreal 1, Que.

Obstetrical Supervisor & Instructor of Nurses. Apply, stating qualifications, Director of Nursing, Victoria Public Hospital, Fredericton, N.B.

General Duty Nurses for new, small hospital in San Joaquin Valley, Calif. Hospital is well-equipped & town offers all the advantages & pleasantness of life in small community within easy travel distance of Oakland & San Francisco. 40-hr. wk. Minimum starting salary: $220. Write Administrator, Community Memorial Hospital, Tracy, California.

Floor Charge Nurses (2). Gross salary: $180. **General Duty Nurses.** Gross salary: $163.40 per mo. 8-hr. broken day. 48-hr. wk. All salaries have scheduled rate of increase. Cumulative sick leave. Pension Plan in force. Blue Cross Plan. 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.

THE PROVINCE OF MANITOBA requires for the HOSPITAL FOR MENTAL DISEASES, SELKIRK, MAN.

SENIOR INSTRUCTOR OF NURSING

Must be Registered Nurse, preferably with Mental Nursing certificate, capable of supervising educational program for undergraduate and graduate nurses, under direction of Superintendent of Nurses.

The above position offers regular annual increases, liberal sick leave with pay, 4 weeks' vacation with pay annually, pension plan, etc.

Apply at once to:

MANITOBA CIVIL SERVICE COMMISSION
247 Legislative Bldg., Winnipeg., Manitoba

Or to your nearest National Employment Service Office.

Matron. State experience. **Registered General Duty Nurses (6).** Starting salary: $140 per mo. plus full maintenance. For General Hospital, Portage La Prairie, Manitoba. Apply Sec., Hospital Board, Box 1055, Portage La Prairie, Man.

Dietitian for 60-bed hospital. Good salary. Apply Supt., Public Hospital, Smiths Falls, Ont.

General Duty Nurses. 8-hr. duty. Salary: $120 per mo. with full maintenance. $5.00 increase after 6 mos. & again after 1 yr. service. 1 mo. vacation after 1 yr. service. Apply, with references, Miss G. Emmerson, Supt., General Hospital, Kenora, Ont.

Public Health Nurse for staff of Elgin-St. Thomas Health Unit. Present minimum salary: $1,900 plus Cost of Living Bonus $180 per yr. Suitable adjustments made in salary for experience to maximum salary of $2,600 & Cost of Living Bonus. Car allowance: $720 per yr. 4 wks. vacation. Cumulative sick leave at rate of 1½ days per mo. unexpended up to 90 days. Admission to Pension Plan after 1 yr. service & interest-free loan, if necessary, for purchase of car. Apply Supervisor of Nurses, City Hall, St. Thomas, Ont.

General Duty Nurses for modern, well-equipped 110-bed hospital. Salary: $125 per mo. plus room, board, laundry. Plus additional for night duty. Increase at end of 6 mos. & annually thereafter for 2 yrs. Accumulative sick time; medical & hospital plans available. 30 days holiday after 1 yr. service. Transportation refunded after 6 mos. service from point of entry into Ontario. Apply Supt. of Nurses, Kirkland & District Hospital, Kirkland Lake, Ont.

Registered Nurses (2) for General Duty at Municipal Hospital, Magrath, Alberta. Duties to commence approx. March 1. Magrath is situated 20 miles from city of Lethbridge in southern Alta. New fully modern 25-bed hospital to open in May. Salary: $140 per mo. plus full maintenance. Transportation refunded after 1 yr. service. 3 wks. vacation & all statutory holidays annually. Salary increases regulated by standards of Alta. Ass'n of Registered Nurses. Excellent working & living conditions. Apply, stating year & school of graduation, to Supt.

Nursery Supervisor & General Duty Nurses immediately for 127-bed General Hospital. New wing nearing completion. Full maintenance & 1 mo. vacation in addition to salary which is on scheduled rate of increase. Apply Director of Nursing, General Hospital, Brockville, Ont.

Lady Supt. by March 15 for Souris & Glenwood Memorial Hospital, Souris, Man. Souris is fully modern town. Hospital has 33 beds & employs largely graduate staff. Salary equal any paid in rural Manitoba plus full maintenance. Direct inquiries immediately to W. R. Bell, Chairman, P.O. Box 245 or phone 159 Souris, Man., Souris Exchange.

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Pending the publication of the revised edition of this book, 100 copies are needed for the use of students enrolled in the **School of Nursing, University of Toronto,** 1951-52. Former students who are willing to part with a copy of this book are asked to send it collect to the *Librarian*. Such a gesture will be greatly appreciated.